STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey for Long-Term Care Facilities was conducted 1/16/18 through 1/19/18 and 1/23/18 through 1/26/18. Six complaints were investigated. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 100 at the time of the survey. The survey sample consisted of 34 residents, 31 current residents, and 3 closed record reviews.	E 000		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and	E 036		3/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	Continued From page 1 testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview the facility staff failed to develop and maintain an emergency preparedness training and testing program. The findings included: On 1/25/18 at 3:10 P.M. the facility's Emergency Preparedness plan was reviewed with the Administer. The Administer was unable to provide any documentation that facility had developed a written training and testing program. The Administer stated, "I don't know how to do it, I've not done it before but I have put a call out to the Coalition and Name (local emergency preparedness director)." On 1/26/18 at 11:06 a.m. a Pre-Exit Conference was held with the Administrator, the Director of Nursing, and the Assistant Director of Nursing	E 036	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. 1. Annual training for the Emergency Preparedness Plan has been scheduled. 2. All residents have the potential to be effected by this practice. 3. Administrator or Designee will in-service staff and supervisors to the location and availability of the Emergency Preparedness Plan and the top three most likely events to effect the facility. ADON or designee will in-service new hires during orientation on the location and availability of the Emergency Preparedness Plan and the top three most likely events to effect the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	Continued From page 2 where the above information was shared. Prior to exit no further information was provided.	E 036	Signed documentation of the training will be will be placed in employee file. 4. Administrator or Designee will audit staff randomly for the next three months on their knowledge of the EPP and their role during a disaster. Administer or designee will audit new employee files after orientation to ensure training on Emergency Preparedness Plan and the top three most likely events to effect the facility randomly for the next three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 3	E 037		

staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 4 (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 5 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview the facility staff failed to ensure that initial staff training and testing for their emergency preparedness plan had been completed and documented. The findings included:	E 037	1. A written training plan for the Emergency Preparedness Plan was created. 2. All residents have the potential to be effected by this practice. 3. The administrator will in-service DON and ADON on the training set up for the Emergency Preparedness Plan and what	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 6 On 1/25/18 at 3:10 P.M. the facility's Emergency Preparedness plan was reviewed with the Administer. The Administer was unable to provide any documentation that facility had developed a written training and testing program. The Administer stated, " I have not done physical staff training. I don't know how to do it, I've not done it before but I have put a call out to the Coalition and Name (local emergency preparedness director)." On 1/26/18 at 11:06 a.m. a Pre-Exit Conference was held with the Administrator, the Director of Nursing, and the Assistant Director of Nursing where the above information was shared. Prior to exit no further information was provided.	E 037	topics will need to be covered. 4. Administrator or designee will audit the training for the Emergency Preparedness Plan quarterly for one year for topics needing to be updated based on the facility assessment. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	
F 000	INITIAL COMMENTS An unannounced Medicare-Medicaid Recertification survey for Long-Term Care Facilities was conducted 1/16/18 through 1/19/18 and 1/23/18 through 1/26/18. Six complaints were investigated. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 100 at the time of the survey. The survey sample consisted of 34 residents, 31 current residents and 3 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 7	F 550		

self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	**2580 PRUDEN BOULEVARD SUFFOLK, VA 23434**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 8 Based on observation and staff interview the facility staff failed to promote care in a manner that maintained the dignity of 1 of 34 residents in the survey sample, Residents #20. The facility staff failed to provide dignity to Resident #20 by leaving the room and leaving her uncovered during the middle of her bath to get help from another staff member. The findings included: Resident #20 was admitted to the facility on 02/18/11. Diagnosis for Resident #20 included but not limited to *Multiple Sclerosis (MS) and *Quadriplegia. *Multiple Sclerosis is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS (https://medlineplus.gov/ency/article/007365.htm). *Quadriplegia is the *paralysis of the arms, legs, and trunk of the body (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition). The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 10/13/17 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #20 with total dependence of two with bed mobility, dressing, toilet use and bathing,	F 550	1. Resident #20 was covered. 2. All residents have the potential to be affected by this practice 3. Director of Nursing, or designee, will in-service nursing staff and new hires on the proper procedure for protecting resident□s dignity during bathing. 4. UM/designee will audit 3 residents daily for 4 weeks, then weekly x 2 months to ensure proper dignity during bathing. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 9	F 550		

total dependence of one with eating and personal hygiene. Resident #20 was also coded under functional limitation in Range of Motion (ROM) impairment on both sides for upper and lower extremity.

The comprehensive care plan documented Resident #20 with a significant self care deficit due to disease process related to MS and chronic pain syndrome, requires total assist of two for all mobility and bed bound. The goal: the resident needs will be met with regard to Activities of Daily Living (ADL's). Some of the interventions to manage the goal included but not limited to: Staff to anticipate needs and assist as needed.

On 01/16/18 at approximately 11:29 a.m., the surveyor knocked on Resident #20's who invited the surveyor to come in. The surveyor opened the door and observed the resident lying on her left side; completely exposed with no clothes or covering. The resident asked the surveyor to cover up her upper body because she was naked and cold. The resident stated, "The CNA was giving me a bath but left the room to go get help and she forgot to cover me up." On the same day at approximately 11:32 a.m., the surveyor went to the nurses station and spoke with the RN Supervisor for east unit who came to Resident #20's room and provided covering to the resident. The supervisor stated, "The CNA should have put covering Resident #20 before leaving the room to get for assistance."

An interview was conducted with the Assistant Director of Nursing (ADON) on 1/19/18 at approximately 10:20 a.m., who stated, "This is a dignity issue; dignity should be maintained at all times, the resident should have been covered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 10 with something, a towel, sheet, blanket or something." The facility administration was informed of the finding during a briefing on 1/26/17. The facility did not present any further information about the findings. The facility's policy: It is the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they can understand. Resident Rights and Facility responsibilities are: -Dignity, Respect & Quality of Life. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of is or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other	F 561		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 11 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interview, and facility documentation, the facility staff failed to honor the choices of 1 of 34 residents in the survey sample. Resident #36 was not able to attend Sunday morning worship services as per his choice. The findings include: Resident #36 was admitted to the nursing facility on 4/28/17 with diagnoses that included stroke with left sided weakness. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 11/4/17 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of possible score of 15 which indicated he had no problems in the cognitive skills for daily decision making. The resident was assessed to communicate well and had no problems	F 561	1. Resident #36 was reassured that care will be provided timely to attend service of his choice. 2. To identify other residents that have the potential to be affected the Activities Director or designee will conduct a 100% audit of all residents for their religious preferences/service times with results given to unit managers to ensure care provided in timely manner to attend services. 3. Unit Managers or designee will educate licensed nurses and CNAs and new hires on resident□s preferences on religious services and providing care to the residents in a timely manner to attend services. 4. Activities Director or designee will conduct a 100% audit of attendance with religious services ensure resident preferences are met for two months and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 12 understanding others. He was coded to be mobile via a wheelchair. The care plan dated 1/15/18 indicated Resident #36 attended activities of his choice. On 01/19/18 at 12:28 PM, during an interview, the resident stated he was not able to attend church on Sunday mornings at 9:00 a.m. and he was up by 11:00 a.m. well after church was over. He stated the Certified Nursing Assistants told him they were busy between 6-8 in the morning so can't get up until 11:00 a.m. He stated he told the nursing supervisor, as well as the East Wing Unit Manager Licensed Practical Nurse (LPN) #2 about not attending church. The Unit Manager was interviewed in the presence of Resident #36 and the Unit Manager stated he did not recall the conversation about the staffs failure to get him up for church on Sunday morning, but he would make sure he was up and attending church per his choice. On 1/19/18 at 3:00 p.m., the Activities Director stated she was aware that Resident #36 loved outings, most activities, but was not aware that he was not attending church services on Sunday. She further said she had an activities associate come in on Sunday to record activities, but she did not arrive until 11:00 a.m. on Sundays, thus she did not have a record of any activities with any residents prior to 9:00 a.m. On 1/23/18 at 12:30 p.m., Resident #36 stated he was thankful for everything because he attended church service on 1/21/18 at 9:00 a.m. He stated the Director of Nursing (DON) came to assure him he would not miss Sunday church services in the future.	F 561	then randomly x1. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 13 On 1/26/18 at 11:05 a.m., a pre-exit meeting was conducted with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). The DON stated he expected the resident to be able to attend any activity he chose and made sure he would not miss Sunday morning services. He stated he was not sure why the CNA staff would tell him he could not get up until 11:00 a.m.	F 561		
F 567 SS=B	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not	F 567		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 567	Continued From page 14 exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on Resident Group Interview, staff interview, and facility documentation, the facility staff failed to ensure Resident's had access to their personal fund account 7 days a week. The findings included: On 01/17/18 at approximately 10:30 a.m., a group interview was held with 9 cognitive residents. During the group interview a resident stated she was unable access her personal fund account on Sundays. The resident stated, "There's a sign located on the the Human Resource (HR) office door but there are no posted hours for Sundays to get my money." The surveyor informed the residents they are entitled to have access to their personal funds 7 days a week. Located on the Human Resource office door was a posted sign that reads: Resident Account Hours in Business Office: Mon. - Fri. (9:00 a.m. - 11:00 a.m. & 2:00 - 4:00), Weekend Access: (Sat. 10:00 - 11:00) and Request assistance with on Duty-Nurse. The post did not include resident	F 567	1. Banking hours sign was updated to reflect new times, to reflect 7 days a week accessibility prior to exit. 2. Identify residents who have personal funds in facility have the potential to be affected by this practice. 3. Activities Director or designee will in-service all residents and/or RP□s on new banking hours and location of posting at the next resident council meeting by posting banking hours on each monthly calendar presented to each resident. Letter informing each R.P. of new banking hours 4. Business office Manager or designee will conduct an audit to ensure sign is posted and correct five days a week for two months and then weekly for one month. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 567	Continued From page 15 account hours for Sunday. An interview was conducted with the Business Office Manager on 01/19/18 at approximately 11:25 a.m., who stated "I work Monday - Friday and every other weekend. The resident has access to the funds anytime Monday - Friday when I'm here and the same for the weekends when I work." The Business Office Manager stated the Manager on Duty (MOD) will issue residents their personal funds on the weekends when she's not here. An interview was conducted with the Administrator on 1/26/18 at approximately 10:35 a.m., who stated, "I do understand" and then stated "We have access to our ATM." The facility administration was informed of the findings during a briefing on 1/26/18. The facility did not present any further information about the findings. The facility's policy: Resident Property Management Policy: The facility provides a safe, accessible and appropriate area for the residents to safeguard their money and/or property. Procedure: Residents will have access to their funds during posted banking hours. -The resident banking hours will adhere to the same schedule of hours as community banking institutions.	F 567		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must--	F 582		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 16 (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 17 resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 3 of 34 residents (Residents # 38, #74 and #154) in the survey sample. The findings included: 1. Resident #38 was admitted to the nursing facility on 10/20/17 with a diagnosis of femur fracture. The Minimum Data Set (MDS) assessment dated 11/29/17 coded the resident with a 3 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the skills needed for daily decision making. On review of the Beneficiary Notification Checklists provided by the facility to surveyors it was noted that Resident #38 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a	F 582	1. Residents #38, #74, #54 cited have already been discharged. 2. All residents with potential discharge in next two weeks will be audited to ensure ABN process will be initiated. 3. Administrator or designee will in-service the Director of Social Services on the appropriate use, and when to issue, the ABN notice according to the requirement of the F582 regulations. 4. Administrator or designee will conduct a 100% audit of all short term residents being cut from rehab to ensure the ABN has been issued weekly x2 months and then monthly x1. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 18	F 582		

NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), however no copies of the SNF ABN(CMS-10055) were provided.

Resident #38 started a Medicare Part A stay on 10/21/17, and the last covered day of this stay was 12/4/17. Resident #38 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN(CMS-10055) and an NOMNC(CMS-10123). Only an NOMNC was issued, with verbal notification to the resident on 12/1/17.

2. Resident #74 was admitted to the nursing facility on 10/16/17 with a diagnosis of Alzheimer's disease and failure to thrive.

The Minimum Data Set (MDS) assessment dated 12/11/17 coded the resident with a 3 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the skills needed for daily decision making.

On review of the Beneficiary Notification Checklists provided by the facility to surveyors it was noted that Resident #74 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), however no copies of the SNF ABN(CMS-10055) were provided.

Resident #74 started a Medicare Part A stay on 10/17/17, and the last covered day of this stay

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 19	F 582		

was 10/30/17. Resident #74 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN(CMS-10055) and an NOMNC(CMS-10123). Only an NOMNC was issued, with verbal notification to the resident on 10/27/17.

3. Resident #154 was admitted to the nursing facility on 10/31/17 with a diagnosis of muscle weakness and chronic obstructive pulmonary disease.

The Minimum Data Set (MDS) assessment dated 11/10/17 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had no problems with the skills needed for daily decision making.

On review of the Beneficiary Notification Checklists provided by the facility to surveyors it was noted that Resident #154 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), however no copies of the SNF ABN(CMS-10055) were provided.

Resident #154 started a Medicare Part A stay on 11/1/17, and the last covered day of this stay was 11//9/17. Resident #154 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN(CMS-10055) and an NOMNC(CMS-10123). Only an NOMNC was issued, with verbal notification to the resident on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 20 11/7/17. On 1/25/18 at 11:00 a.m., the facility Administrator and the social worker stated were not aware of the issuance of a SNF ABN when Medicare Part A is discontinued by the provider. They only issued the NOMNC to the residents. No additional information was provided prior to exit.	F 582		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to thoroughly investigate an injury of unknown origin for 1 Resident of 34 in the survey sample, Resident	F 610	1. Resident #78 no correction to be made. 2. All resident that has had an injury of unknown origin have the potential to be effected by this practice.	3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 21 #78. The findings included: Resident #78 was initially admitted to the facility on 9/24/14. Diagnoses listed for Resident #78 included but not limited to Alzheimer's Disease, Arthritis, Osteoporosis and Fracture. Resident #78's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date of 12/8/17, coded Resident #78 as scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) cognitive impairment. The resident was completely dependent on two staff for bed mobility, transfers and toileting. The resident's balance was assessed as not steady, and only able to stabilize with staff assistance for balance during transfers. The Comprehensive Person Centered Care Plan dated 6/1/16 identified the resident required total assistance with ADL (Activities of Daily Living) functioning d/t (due to) Alzheimer's, psychosis, dementia, visual impairment, osteoarthritis and pain. The goal was "She will have ADL's met daily through next review." One intervention listed to achieve the goal was to transfer with total assist of two staff using a total lift. Resident #78 was at also identified at risk for falls related to decreased mobility, weakness, short and long term memory deficit, impaired vision (prefers to remain in bed for comfort ...only gets up once-twice a week). One intervention included call bell within reach. The goal was "She will have no preventable injury from falls thru next review." The care plan updated on 11/15/17 documented, Right Tibia Plateau fracture with the goal of "Will	F 610	3. Administrator or designee will in-service department heads on thoroughly investigating injuries of unknown origin to rule out allegations of abuse, neglect, exploitation or mistreatment and how to maintain thorough records of investigation including statements by staff interviewed. 4. Administrator or designee will conduct a 100% audit of all injuries of unknown origin for complete investigation weekly for 3 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 22	F 610		

have maximum functional mobility." Interventions: Included but were not limited to: Leg brace on and off per MD (Medical Doctor's) orders; Monitor Pain; Ortho follow up as needed; Circulation checks to affected limb.

The CNA (Certified Nursing Assistant) Kiosk (a computer station CNAs use to document and see the Resident's assessed needs) documented on Page 3 of 3: ADL (Activity of Daily Living) Section: Transfers with total assist of two using total lift.

The Kardex Report printed 1/24/18 and received on the same date at approximately 11:35 AM, documented the following: ADL: Transfers with total assist of two using total lift.

A Facility Reported Incident was received on 11/14/17 at the State Agency. The report stated the resident was found with an injury of unknown origin. An x-ray was obtained and confirmed a potential tibial fracture.

The facility's investigation of the injury of unknown origin concluded, based on the results of the investigation, "we determined the hairline fracture occurred during a bed transfer via total mechanical lift. The lift was used appropriately with two CNAs present. We believe when the resident was in the lift and being transferred from the bed to chair, her leg remained in contact with the mattress, potentially putting pressure at the knee and causing the hairline fracture."

Further record review evidenced the following: 11/14/17 X-Ray Report: Knee

Results: No previous studies are available for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 23	F 610		

comparison. There is a depressed fracture of the medical tibial plateau which appears new. The knee joint is significantly narrowed.

Conclusion: Findings are consistent with an acute fracture involving the medial tibial plateau.

Addendum: There is proximal tibial shaft medical subcortical hairline fracture without displacement.

An 11/16/17 Nurse Practitioner #4 note documented: "(Resident #78) is a recent Tibial Plateau fx (fracture) to R (Right) leg. She states the knee was caught in a chair. She was seen by (Orthopaedic and Spine Specialist) today and knee Immobilizer with padding - has FU (follow up) in 2 wk's (weeks) 11/20/17."

Resident #78's 11/16/17 Orthopaedic and Spine Specialist note documented the following:
"CC: (Chief Complaint) Right Knee Pain

HISTORY: (Resident #78) is 87 y.o. (year old) female who is seen for right knee pain. She first complained of pain on 11/14/17 after her knee got caught on a chair at (Facility) while getting her hair done. She had right knee x-rays at (Facility) on 11/14/17 that revealed a medical plateau fracture...History is somewhat lacking and unreliable due to non verbal state. Her daughter is present today. She has not walked since her great toe amputations 4 years ago by ... She is hypertensive. She has a h/o (history of) peripheral vascular disease..."

During review of the facility investigation, staff statements revealed the following:

CNA #20 documented that she cared for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 24	F 610		

Resident #78 on 11/11/17 and "she did not complain of any pain during care."

CNA #21 documented that Resident #78, "didn't complain of any pain during AM care on 11/9/17 or 11/10/17. On 11/9/17 after doing ADL's I got (Resident #78) dressed and up into her chair, and still there were no complaints of pain. Her daughter and son-in-law came to visit her on 11/9/17 and I left her sitting up in the chair with her family. I also had (Resident #78) on 11/10/17 I performed ADL care and (Resident #78) still never complained of any pain. I didn't get her up on Saturday 11/10/17 because she didn't' want to get up because she was up the day before."

A statement taken from Resident #78's daughter and documented by the Unit Manager #1, dated 11/14/17 at 2 PM documented the following: "...she was here on 11/9/17 to visit her mother. She stated that she (Resident #78) did not complain of any pain during the visit. There was nothing different with her while visiting."

CNA #22 documented the following: "... I (CNA #22) had (Resident #78) on 11/12/17. She didn't complain about pain while doing her ADL care and second rounds."

CNA #23 documented the following: "To whom this may concern, on 11/13/17, I (CNA #23) assisted (CNA #7) with patient transfer via hoyer lift bed ... After transferring patient had no complaints."

In addition to the above 11/14/17 dated staff statements, an undated and unsigned statement from the Social Worker #2, was reviewed. The Social Worker documented: (Resident #78)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 25	F 610		

"BIMS Score completed with (Resident #78), She Scored 3/15. When asked what happened to her leg she was unable to give a complete story. Social Services asked (Resident #78) what happen she stated she didn't want to go to dinner and she stayed in bed. She was then asked did she get up and fall, she stated she is unable to walk. She then pointed to her chair stated is (it) was not stretched out enough. (Resident #78) continued to state it was the bottom of the chair. When asked did her leg get caught she would not answer. When asked did she sit on it she would not answer. When asked how much pain she was in and where the pain was she stated in her right leg and only hurts when she moves it."

Review of a 11/16/17 document from the Administrator documented the following: "On Tuesday, November 14, 2017 resident complained of pain in her leg and resident's right knee noted to be edematous. An X-Ray was ordered and taken. X-Ray results showed a right Hairline tibial fib fracture, Resident denied any further pain. Call placed to the MD and ...NP ordered a leg immobilizer and ortho f/u. Administrator made aware of results and an investigation began. F.R.I. completed on 11/14/17. Spoke with CNA's who provided care to Resident dating back from 11/9/17. Interviews with (CNA #24, CNA #21, CNA #22, CNA #7, CNA #25, CNA #26, CNA #20 and CNA #23). Upon interviewing these individuals, it was noted that (Resident #78) did not complain of any pain while receiving care until 11-14-17. Resident has scheduled Norco 5-325 mg (milligrams) BID (twice daily) and a PRN (as needed) Norco 5-325 mg q4h (every 4 hours). Daughter...was made aware in the process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 26	F 610		

Information gathered from the above mentioned staff members and narrowed down to two individuals. After speaking with (CNA #7 and CNA #23) with role play return demonstration, it was concluded that poor procedure was used when transferring resident into geri chair. Policy and practice was followed per total lift use. However resident's bed was positioned in such a way as the residents legs were slightly dragging on bed when resident was removed from the bed via lift.

With this information we have determined the resident's body left the bed before her feet potently (potentially) causing the hairline fracture. No deficient practice noted during return demonstration however we will be in servicing on observing leg placement while using Hoyer lift."

A document dated 1/19/18 by the Facility Administrator #1, written to clarify his 11/16/17 document statement of "poor procedure" documented the following: "As a clarification to my previous statement of "poor procedure was used," this was intended to highlight the potential issue when using the total lift and the need to educate. The CNA's use of the lift at the time was in accordance to the training materials provided to them. The training material does not mention the need to lower the bed once the resident is secured in the lift."

Review of a 11/17/17 letter sent to the State Agency, from the Administrator to follow up the 11/14/17 Injury of Unknown Origin FRI documented the following: "... An investigation was completed to included interviews with the resident, staff members and a clinical record review. Based on the results of the investigation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 27	F 610		

we determined the hairline fracture occurred during a bed transfer via total mechanical lift. The lift was used appropriately with two CNA's present. We believe when the resident was in the lift and being transferred from the bed to to chair, her leg remained in contact with the mattress, potentially putting pressure at the knee and causing the hairline fracture. No deficient practice noted during return demonstration however, we will be in-servicing on observing leg placement while using mechanical lift. Resident has no complaints of pain and is being followed by Ortho with no new orders noted at the time."

Review of a document given by the DON on 1/19/18 at approximately 10:05 AM, documented a timeline of Resident #78's fall. This document was not dated and was not signed. The DON reviewed the documented information on the 1/19/18 document at approximately 10:05 AM. The document regarding the incident included the following:

Fall:

11/14/17 resident c/o (complained of) pain in leg, right knee noted to be edematous
11/14/17 resident medicated for pain with no other c/o pain on 11/14/17
11/14/17 x-ray completed with result of hairline fx (fracture) of tib (tibia), fib (fibula).
11/14/17 M.D. (Medical Doctor) aware of x-ray results order for immobilizer placed and Ortho f/u (follow up)
11/14/17 Administrator made aware, investigation started, F.R.I. completed
11/14/17 Interviewed C.N.A.s providing care dating back from 11/9/17, resident did not complain of pain before 11/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 28	F 610		

11/14/17 from staff interviews we narrowed investigation to two staff members. (CNA #23 and CNA #7)
11/15/17 second interview including role play with physical demonstration revealed cause of fx. (fracture). Staff members had resident in total lift when resident buttocks left bed causing increased pressure to legs that were still on bed.
11/16/17 Ortho appointment confirmed fx (fracture)

Review of CNA #7's employee file included a document "Employee Acknowledgement of Receipt of Fraud and Abuse Policy" dated and signed 9/27/17. Review of CNA #7's employee file also included a documented dated and signed by CNA #7 on 9/27/17 that he had received, read, and understood the following policies: Safe Resident Transfer Policy. Review of CNA #7's employee file documented that he was removed from the payroll effective date 11/21/17 for insubordination.

On 1/19/18 at approximately 12:30 PM, an interview was conducted with the Director of Nurses (DON) #2, the Administrator #1, and the Regional Clinical RN (Registered Nurse) #4. The Regional Clinical RN stated that the 2 CNAs involved performed the procedure correct per their investigation. The Administrator was asked to clarify his statement "poor procedure was used" and he stated that he meant "due to fracture during transfer" and was asked to write another document explaining his intention/meaning of the words.

The group was asked if a Corrective Action Plan was done and the Regional Clinical RN stated: "No, it wasn't as we felt there was not a deficient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 29	F 610		

practice." The Administrator #1 stated that his investigation showed that Resident #78's pain began on 11/14/18 and the facility investigation felt it was related to the 11/13/17 transfer of two CNA's (CNA #7 and CNA #23). The DON was asked if the fracture was caused by a fall as documented on the timeline form. The DON stated that Resident #78 did not fall.

On 1/19/18 at approximately 10:05 AM, the DON #2 stated that Resident #78's pain started on 11/14/17. The DON was asked for an employee statement from CNA #7 as it was not included in the group of employee statements.

On 1/19/18 at approximately 1:30 PM, the DON along with CNA #27 and LPN (Licensed Practical Nurse) #2 performed a simulation of a transfer using a Hoyer lift. The DON stated that he felt that during transfer the Resident's leg may have bumped back into the mattress as the resident's leg was coming off the mattress.

On 1/19/18 at approximately 2:45 PM, CNA #23 was interviewed. CNA #23 stated that she was asked to help by CNA #7 for the transfer. CNA #23 stated she had hands on bar of lift, the bed was raised, as she was pulling back, CNA #7 was assisting the patient. CNA #23 was asked if Resident #78 started complaining of pain during the transfer, or if she saw the resident's legs hit or get stuck during the transfer. CNA #23 stated: "Not that I remember." CNA #23 stated that staff were in-serviced about being mindful of objects surrounding, to always use two people and to immediately report any pain the resident may have. CNA #23 was asked if there is a document on the inside of the Resident's closet door that states how a resident is to be transferred. CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 30	F 610		

#23 stated, "No." CNA #23 stated that she was involved in a re-enacted role-play of transfer with a Hoyer lift. She stated that CNA #7 was not involved in the role-play as he was off on 11/14/17.

On 1/23/18 at approximately 10:48 AM, Resident #78's daughter was called. The daughter stated that she was notified of the fracture and she recalled on the day that she had requested that her mother be gotten up so that she could go to the beauty parlor. The daughter was not in the room when Resident #78 was gotten out of bed.

On 1/23/18 at approximately 4:16 PM, CNA #7 was called by phone, by the Administrator with the DON and survey team present. After introductions of all present in the room, CNA #7 was asked to explain what happened as he was caring for Resident #78 on 11/13/17. CNA #7 stated that he had to have all his residents up before lunch. CNA #7 stated that he was in the room performing ADL care on Resident #78 and he needed help to get her out of bed. He stated he asked CNA #23 to help. When asked how Resident #78 was gotten out of bed, CNA #7 stated that he did a Pivot to stand transfer. CNA #7 stated that Resident #78 had complained of hurting before the 11/13/17 transfer. CNA #7 stated that he was on the Resident's Right side while CNA #23 was on the Resident's Left side. CNA #7 stated they put their arms under the Resident's arms and stood her and placed her in the chair. CNA #7 stated he thought there was pressure on the Resident's legs. CNA #7 stated that the next day (11/14/17) he was off. CNA #7 stated on 11/14/17 he received a call from the DON and was informed that Resident #78's leg might be broken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 31	F 610		

CNA #7 stated during the phone interview that on 11/15/17 when he returned to work, he was informed that the DON wanted to talk with him. CNA #7 stated that the conversation included the Unit Manager #1, LPN #1, the DON #2 and himself CNA #7. CNA #7 stated that the DON asked him what happened, and encouraged him to tell the truth. CNA #7 stated that he told them that he did not use the Hoyer lift when he transferred Resident #78 on 11/13/17. Then CNA #7 stated that he did not receive a verbal warning or a written statement regarding the transfer. CNA #7 stated that he did do a witness statement and gave it to the DON. CNA #7 did not keep a copy of his witness statement. Neither the Administrator nor the DON recalled the specifics of CNA #7's missing Witness Statement.

During the phone conversation with CNA #7, as he stated he did not use the Hoyer Lift, the Administrator and DON were observed shaking their heads from left to right as in a no response.

The Administrator was asked about the cause of the fracture. The Administrator stated that the Conclusion was when removing the Resident from the bed her feet had contact with her.

After the phone call, both the Administrator and the DON stated that CNA #7's statement was not what he had told them previously. Both the Administrator and the DON stated that they have not found a copy of CNA #7's written statement. When asked why CNA #7 was not included in the education that was done for the facility, the DON stated that CNA #7 did not work on 11/14/17 and was terminated soon after. The Administrator stated that it was the Facility's conclusion based

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 32	F 610		

on information they had received during their investigation, was that the fracture cause was related to the lift. The Administrator was asked if as the Administrator if he had seen CNA #7's Witness statement. The Administrator stated he spoke with him and was never told that the transfer did not occur in any way other than by the Hoyer lift.

The Social Worker's written statement was read by another surveyor and commented that the document was neither dated nor signed. On 1/25/18 at approximately 2:45 PM, the Social Worker when asked when she wrote her document, went into her document history and pulled up the same document to show that it was written on 11/14/17 at 4:18 PM.

The Administrator stated: "We can't be having this. That's going to change." The Administrator also stated, "This building had a history of covering up." When asked for clarification none was given. The Administrator on 1/23/18 at approximately 4:56 PM, stated that he constantly tells staff if they feel they are not heard they can go above him and call the Hot Line Number. The Administrator stated that if he (CNA #7) was told to do something fraudulent he should have come to him or called the hot line number.

On 1/23/18 at approximately 6:15 PM, the Regional Clinical RN stated that after the incident of Resident #78's fractured leg, the facility identified that a second CNA will be used to guide the legs during a Hoyer lift transfer. She stated, "We didn't identify a deficient practice, so we didn't do a Corrective Action Plan. The Administrator was informed that the Policy and Procedure of Hoyer Lift #8 stated: "Provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 33	F 610		

Support" and the Administrator stated that there are many ways of support, and that the word support doesn't just mean hands on support. He stated it could also mean emotional support during the transfer.

On 1/25/18 at approximately 11:48 AM, CNA #23 was interviewed again. CNA #23 was informed that on 1/23/18 a meeting with the DON, the Administrator and CNA #7 on phone along with the State Surveyors was conducted. CNA #23 was informed that CNA #7 had stated that he did not use a Hoyer lift during transfer of Resident #78. CNA #23 was asked if she would like to amend or to change her previous written witness statement. CNA #23 was silent for a few moments. CNA #23 was asked again if she wanted to amend or change her previous statements of using a Hoyer lift with CNA #7 on 1/13/18. After a few more moments, CNA #23 stated that CNA #7 put his arms under the Resident's arms and lifted her and then twisted her into the Geri Chair. CNA #23 stated that she felt influenced to say she assisted in a Hoyer Lift transfer as it was the correct way that Resident #78 was to be transferred. CNA #23 was heard by three Surveyors to say prior to her exit from the conference room, "I'm sorry; I should not have done that."

The Facility Policy and Procedure titled, "Incident/Accident Report" with a revision date of February 2016, documented the following: Section 6. Witness statements: a. Witnessed incident/accident - The nurse will immediately begin collecting witness statements from any staff, family member, visitor and/or other residents that witnessed incident/accident. In addition, the Policy and Procedure documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 34	F 610		

the following:
Injury of Unknown Source. An injury is classified as an "Injury of Unknown Source" when both the following conditions are met:
a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; AND
b. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time.
Section 7 of the Incident/Accident Report Policy and Procedure documented the following:
Investigate
Once the Administrator and DOH (Department of Health) are notified, an investigation of the allegation or suspicion will be conducted.
b. Investigation protocol. The person investigating the incident should generally take the following actions:
I. Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employees) and/or alleged victim the day of the incident.
III. Obtain written statements from the resident, if possible, the accused and each witness.
V. If the accused is an employee, then review his/her employment records.
c. Documentation. Evidence of the investigation should be documented.

The Facility did not produce a written statement from CNA #7, assigned to Resident #78 the day prior to her reported pain. Further investigation by the State Agency evidenced the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 35	F 610		

investigation was not thorough and was incorrect. The resident was transferred from the bed without the use of a total lift device. As a result, the resident sustained a fracture to the tibial plateau.

The Facility Guidance given to the surveyor from the Administrator titled, "Transfer Techniques" without a date and without a reference, documented the following:
Responsibility: Therapist
Before initiating treatment, the patient/resident is evaluated by the therapist to determine appropriateness and method of transfers to be utilized.
Staff to know patient/residents diagnosis and/or precautions
Apply Gait/transfer belt as determined by Therapist: Recommended if patient/resident requires physical assistance greater than 25% of task and position of belt does not compromise respiratory status, incisions, IV's etc
Explain entire procedure to patient/resident

The DON stated on 1/26/18 at approximately 2:45 PM, that he could not find any guidance for stand pivot transfers for CNA use. The DON stated that it was his expectation that if a stand pivot transfer was used, that a gait belt should be used and that the resident be able to pivot. The DON stated that Resident #78 was not able to pivot.

The facility administration was informed of the findings during a pre-exit conference on 1/26/18 at approximately 11:05 AM and again during the Exit Conference on 1/26/18 at approximately 3:30 PM. The facility did not present any further information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 642	Continued From page 36	F 642		
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, and facility documentation, the facility staff failed to complete and accurate Quarterly Minimum Data Set (MDS) with an Assessment Reference Date ARD of 12/19/17 for 1 of 34 residents (Resident #4) in the survey sample.	F 642	1. New Quarterly MDS will be for resident #4 completed accurately and submitted. 2. All residents have the potential to be effected by this practice. 3. Regional MDS consultant or designees will in-service MDS coordinator on completing and providing an accurate	3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 642	Continued From page 37 The findings included: Resident #4 was originally admitted to the facility on 09/08/17. Diagnosis for Resident #4 included but not limited to *Alzheimer's Disease and *Muscle Weakness. *Alzheimer's is the common form of dementia. A progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment (Source: http://www.cdc.gov/aging/aginginfo/alzheimers.htm). *Muscles weakness is reduced strength in one or more muscles (https://medlineplus.gov/ency/article/007365.htm). During the review of Resident #4's quarterly MDS with an ARD of 12/19/17, section C (Cognitive Patterns) asked the question, "Should Brief Interview for Mental Status be Conducted" the MDS was coded with a dash and section C was marked with dashes. Section D under Mood asked the question "Should Resident Mood Interview be Conducted" was coded with a dash, and section D was marked with dashes. Section J under (Health Conditions) asked the question, "Should Pain Assessment be interview be conducted" the MDS was coded with a dash, and section J was marked with dashes. Section Q (Participation in Assessment and Goal Setting) was also coded with dashes. In addition, the MDS coded Resident #4 requiring total dependence of one with bathing, extensive assistance of two with transfers and limited assistance of one with dressing eating , toilet use and personal hygiene.	F 642	MDS assessment. 4. MDS coordinator or designee will conduct a 100% audit of all MDS□s due weekly for two months and then monthly x1. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 642	Continued From page 38 An interview was conducted with the Interim MDS Coordinator on 01/25/18 at approximately 8:30 a.m., who stated, "Section C under Cognition, section D under Mood, section J under Pain and section Q under assessment should have been completed during a quarterly assessment." An interview was conducted with the Social Worker on 1/26/18 at approximately 8:30 a.m., who stated, "The MDS was not opened up on time so I was unable to finish my sections of the MDS timely but I did complete my section of the MDS on 12/29/17 but after the ARD date which made my entry late." The facility administration was informed of the finding during a briefing on 01/26/18. The facility did not present any further information about the findings. CMS's RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI) 1). 1.3 Completion of the RAI (1) the assessment accurately reflects the resident's status. Goals: The goal of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in the nursing home care requested that MDS 3.0 revision focus on improving the tool's clinical utility, clarity, and accuracy.	F 642		
F 657	Care Plan Timing and Revision	F 657		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 SS=D	Continued From page 39 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews, medical record review, and facility document review, the facility staff failed to ensure that care plans were revised and residents were invited to care plan meetings for 3 of 34 Residents in the Survey Sample, Resident # 81, Resident #38, and Resident #150. 1. The facility staff failed to ensure that Resident	F 657	1. Resident # 38 and #150 were discharged from facility. Care plan invite for resident #81 was sent for upcoming care plan. 2. All residents have the potential to be effected, Residents with diet changes or receiving psychotropic medications, has the potential to be effected by this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 40 #81 was invited to her care plan meetings. 2. The facility staff failed to develop a care plan for Resident #38 who was receiving a psychoactive medication *Seroquel. 3. The Facility staff failed to revise Resident #150's care plan to reflect a change from thin liquids to thickened liquids. The findings included: 1. Resident #81 was a 70 year old admitted to the facility on 6/23/17 with diagnoses to include Hypertension and Major Depressive Disorder. The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 12/7/17. The Brief Interview for Mental Status (BIMS) was a 14 out of a possible 15 which indicated that Resident #81 was cognitively intact and capable of daily decision making. On 01/16/18 01:05 PM during a resident interview Resident #81 stated she is not invited to her care plan meetings when asked about care plan meetings by this surveyor. On 01/19/18 1:55 PM an interview was conducted with the facility Social Worker regarding care plan meetings. The Social Worker was asked if she was responsible for sending out care plan invites, who received them for Resident #81, and when was her last care plan meeting held. The Social worker stated, "I send out the care plan invites and I send hers to her cousin/POA (Power of attorney). She was scheduled for a care plan on December 7, 2017 and I sent a invite to her	F 657	practice. 3. Administrator or designee will in-service the Department Managers on updating/revising care plans for changes noted. Administrator or designee will in-service the social services director on updating care plans and inviting residents and families to care plan meetings to include written documentation. Director of Nursing, or designee, will in-service licensed nursing staff on revising care plans accordingly. 4. Administrator or designee will conduct a 100% audit of all care plan invitations weekly for three months. MDS Coordinator or designee will conduct a 100% audit of all residents care plans at the time of the care plan meeting for accuracy and completion for three months. DON, or designee, will audit care plan updates daily for two months and then weekly for one month. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 41	F 657		

cousin but the care plan got changed to December 19, 2017 and it was missed, it was never done and I never sent an invitation out about the new care plan date. We just missed it. The surveyor asked, "Is the resident incompetent"? The Social Worker stated, "I don't think so, I should have made sure she received an invitation too. I will make sure she get one from now on."

The facility policy titled "Care Plan Invitation Letter Policy" revised February 2016 was reviewed and is documented in part, as follows:

Policy: The resident and the resident's Responsible Party or legal representative must be invited to attend each of the Interdisciplinary Care Planning Conferences for the specified resident.

Procedure:

1. The Executive Director and Administrator will designate a staff member who will be responsible for completing the Care Planning Invitations, for delivering an invitation to the resident, and for mailing an invitation to the Responsible Party or legal representative.

3. The facility designee will deliver an original Care Planning Invitation to the resident 5 days prior to the date of the conference, unless he/she has been deemed legally incompetent. A copy of the invitation will be maintained with the medical record as verification that it was delivered.

On 1/26/18 at 11:06 a.m. a Pre-Exit Conference was held with the Administrator, the Director of Nursing, and the Assistant Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 42	F 657		

where the above information was shared.

Prior to exit no further information was provided.
2. Resident #38 was originally admitted to the nursing facility on 10/20/17. Diagnosis for Resident #38 included but not limited to *Bipolar Disorder and *Dementia with behavioral disturbance.

*Bipolar Disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again (https://medlineplus.gov/ency/article/007365.htm).

*Dementia with behavioral disturbances is frequently the most challenging manifestations of dementia and are exhibited in almost all people with dementia (https://www.ncbi.nlm.nih.gov/pubmed/22644311) .

The current Minimum Data Set (MDS) a Medicare 5-day assessment with an Assessment Reference Date (ARD) of 11/29/17 coded the resident with a 03 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.

The review of Resident #38's Medication Administration Record (MAR) indicated was started on Seroquel tablet 100 mg by mouth twice a day for bipolar disorder on 1/9/18.

*Seroquel tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 43	F 657		

patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) ((https://medlineplus.gov/ency/article/007365.htm).

The review of the Resident #38's comprehensive care plan did not include a care plan for the use a psychoactive medication.

An interview was conducted with the Regional Reimbursement Specialist on 1/25/18 at approximately 12:00 p.m., who stated the medication Seroquel should have been care planned. The surveyor asked about the process for updating a resident centered care plan, to which she replied, "We have a meeting every morning where all residents are reviewed and at that time the care plan should be updated."

The Interim MDS Coordinator stated, "The MDS Coordinator only update care plans on a quarterly basis but the nursing staff should update the care plan on a continuous basis."

On 1/26/17 at approximately 11:20 a.m., and interview was conducted with the Director of Nursing (DON) who stated, "Yes, the medication Seroquel should have been care planned."

The facility administration was informed of the finding during a briefing on 1/26/18. The facility did not present any further information about the findings.

The facility's policy: Care Planning Guidelines (Revised 4/06/17).

Policy:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 44	F 657		

-An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. In states where pre-admission screening applies, this will be coordinated with the facility assessment. Goals must be measurable and objective.
3. Resident #150 was admitted to the nursing facility on 7/24/13 with diagnoses that included Parkinson's Disease.

The most recent Minimum Data Set (MDS) was a significant change in status assessment dated 12/5/17 and coded the resident with a score of 3 out of a possible 15 on the Brief Interview for Mental Status which indicated the resident was severely impaired in the skills for daily decision making.

Resident #150 had physician's orders dated 12/15/17 for nectar thickened liquids. On 1/17/18 at 10:00 a.m., although Resident #150 did not take his morning medications, Licensed Practical Nurse (LPN #10) poured un-thickened water to in preparation to offer the resident. The LPN stated he was not aware of the resident's order change for thickened liquids.

The care plan dated as revised on 12/12/17 was not further revised on 12/15/17 to indicate the resident was placed on nectar thickened liquids.

On 1/17/18 at 12:30 p.m., an interview was conducted with the East Wing Unit Manager, LPN #2. He stated the care plan should be updated with any new orders to include a change in diet and liquid consistency. He also stated he expected LPN #10 to have offered the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 45 the liquid consistency as per physician's orders. On 1/26/18 at 11:05 a.m., a pre-exit meeting was conducted with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). The DON stated he expected physician's orders to be followed and recommendations to offer the resident nectar thickened liquids, as well as updated on the care plan. He also stated any nurse can revise a resident's care plan. The facility's policy and procedure titled Care Plan dated 4/6/17 indicated, if necessary, the Minimum Data Set (MDS) coordinator was responsible to ensure a resident's care plan was reviewed and updated prior to the scheduled care plan conference.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, and clinical record reviews, the facility staff failed to provide personal care for 2 residents in the survey sample of 34, who were unable to independently carry out activities of daily living (ADL's); Residents #4 and #36. 1. The facility staff failed to ensure Resident #4 received her bi-weekly showers. 2. The facility staff failed to ensure Resident #36	F 677	1. Residents #4 and #36 offered a shower after facility was made aware. 2. All residents have the potential to be effected by this practice. 3. Director of Nursing or designee will in-service the Unit Managers on insuring showers are scheduled and completed. 4. Unit manager, or designee, will audit bathing care daily for random residents for three months and then weekly for one month.	3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 46 received his bi-weekly showers. The findings include: 1. Resident #4 was originally admitted to the facility on 09/08/17. Diagnosis for Resident #04 included but not limited to *Alzheimer's Disease and *Muscle Weakness. *Alzheimer's is the common form of dementia. A progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment (Source: http://www.cdc.gov/aging/aginginfo/alzheimers.htm). *Muscles weakness is reduced strength in one or more muscles (https://medlineplus.gov/ency/article/007365.htm). The current MDS (Minimum Data Set) a quarterly with An Assessment Reference (ARD) date of 12/19/17 coded resident #4 requiring total dependence of one with bathing and extensive assistance of one with personal hygiene. The comprehensive care plan documented Resident #4 with self-care deficit. The goal: will achieve maximum functional abilities. Some of the interventions to manage goal included bathing/hygiene with staff assist of one and dressing/ grooming with staff assist of one. An interview was conducted with Resident #4 on 1/19/18 at approximately 12:27 p.m., who stated "I'm not getting my showers; I only have had one shower since I've been here." The resident proceeded to say, "If I ask for a shower the staff	F 677	The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 47	F 677		

have said; I'll come back later, and at one time the CNA told me the shower room is not being used right now."

On 1/19/18 an interview was conducted with Unit Manager on East Wing who stated, "Resident #4 was never put into the computer system so she would have never showed up to receive her showers." The unit manager also stated that "we have a shower book and all the CNA's should be checking the shower book, as well as the computer, to make sure everyone receives their shower on their shower days."

1/19/18 at 11:05 a.m., an interview was conducted with CNA #10 who stated "we were not using the shower room due to renovation and resident was logged into the computer for shower - didn't check shower book; my fault."

1/19/18 at 11:00 a.m., an interview was conducted with CNA #11 who stated she "don't recall seeing Resident #4 in the computer, I go straight to the computer; I didn't check the shower book to check to see if the resident should have received a shower."

An interview was conducted with CNA on 1/19/18 at approximately 11:25 a.m., who stated "I didn't give Resident #4 her shower and I didn't check the shower book but the room changes doesn't always make it to the computer system."

The review of the east wing shower book indicated that Resident #4 should be receiving her showers on Wednesday and Saturday (7-3 shift).

The facility's policy: Bathing and Showering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 48	F 677		

Policy: Assistance with showering and bathing will be provided twice a week and as needed to cleanse and refresh the resident.
2. Resident #36 was admitted to the nursing facility on 4/28/17 with diagnoses that included stroke with left sided weakness..

The most recent Minimum Data Set (MDS) assessment was a quarterly dated 11/4/17 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of possible score of 15, which indicated he had no problems in the cognitive skills for daily decision making. The resident was assessed to communicate well and had no problems understanding others. The MDS coded the resident as able to do part of bath or shower with the assistance of one staff. He had limitations in range of motion on one side in upper and lower extremities.

The care plan dated 1/15/18 indicated Resident #36 required assistance for ADLs due to his history of stroke with left sided hemiplegia and arthritis. The goal set by the staff for the resident was that he could wash his face and brush his teeth and could assist to wash upper body, but needed assistance bathing other parts of his body. Bathing and showering assistance would be the job of the Certified Nursing Assistant.

On 01/19/18 at 12:27 PM, during an interview with the resident, he stated since he moved to his new room in October 2017, he was not getting his showers, but only "wash-up" and bed baths. The resident stated that after he has a bowel movement with feces smeared everywhere he never felt clean enough and was desirous of his showers. Additionally, the resident stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 49	F 677		

never refused a shower. The shower logs on the East Wing scheduled the resident for the 7-3 shift on Monday and Thursdays. The Activities of Daily Living (ADL) logs did not capture showers for the resident. The Unit Manager, Licensed Practical Nurse (LPN) #2, was brought in on the interview with the resident. The Resident stated he was not getting his showers and he had told him and other nurses about the issue. The Unit Manager responded and said he did not recall the conversation, but he would check into it. It was later confirmed by the Unit Manager that when the resident was transferred within house to Room (number), his shower schedule was not changed to reflect the resident was in the room at the door, thus his showers would be Monday and Thursday on the 3-11 shift, and the resident was being missed due to the room change and bed status change. The Unit Manager stated he was going to fix the situation and the resident would be receiving regular showers.

On 1/19/18 at 1:30 p.m., the assigned Certified Nursing Assistant (CNA) #5 stated she was not sure about when the resident's showers were and had not ever given him one.

On 1/23/18 at 12:30 p.m., Resident #36 stated the staff did a make up shower on Friday 1/19/18 on the 3-11 shift, plus he got one on 1/22/18 as well.

On 1/26/18 at 11:05 a.m., a pre-exit meeting was conducted with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). The DON stated he was not aware that the resident was not receiving showers. He stated he instructed staff to document when showers were not given and follow-up would take place to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 50 find out the reason. There were no nurse's notes to reflect issues with showers to include the resident refusing them.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility staff failed to provide the necessary care and services to maintain the highest practicable physical well being for 2 of 34 residents in the survey sample, Resident #100 and Resident #94. 1. The facility failed to follow the physician orders for the administration of eye drops for the treatment of glaucoma for Resident #100. 2. The facility staff failed to follow physician's orders for Resident #94 and administer B Complex with folic acid. The findings included: 1. Resident #100 was admitted to the facility from the hospital on 1/3/18 with diagnoses to include but not limited to glaucoma.	F 684	1. The physician□s order for the Timolol eye drops has been corrected for resident # 100. The order for B-Complex with Folic acid has been corrected for resident # 94. 2. All residents have the potential to be effected by this practice. 3. Director of Nursing or designee, will in-service licensed nursing staff on transcribing and following physician orders. 4. Unit manager, or designee, will audit new orders weekly for three months and then random weekly for one month. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 51	F 684		

The admission MDS (Minimum Data Set) with an assessment reference date of 1/10/18 coded the resident as scoring a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. Under Section B. 1000 Vision the resident's ability to see in adequate light was not assessed and dashed. B. 1200. coded the resident as using corrective lenses.

The baseline care plan initiated on 1/3/18 identified the resident as having impaired vision as she has glasses and is being treated for glaucoma. The goal was that the resident would be able to safely participate in activities of daily living. One of the interventions listed to achieve the goal was revised on 1/18/18 and included the administration of eye medications as ordered.

01/17/18 at 3:01 PM, the resident was observed in the small activity room, sitting in a wheelchair, asleep and leaning to the right side. A family member was visiting with the resident at this time. The family member stated the resident was on two eye drops at home prior to the hospitalization for the treatment of the glaucoma and one eye drop for dry eyes (artificial tears). The family member stated she believed the resident was not receiving all three while here at the facility.

The hospital discharge medication list dated 1/3/18 was reviewed. The medications that were to be continued after discharge included two eye drops for the treatment of glaucoma:
1. Dorzolamide-timolol (Cosopt) 2-0.5% one drop in affected eye(s) twice daily.
2. Travoprost 0.0004% one drop in affected eye(s) every night at bedtime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 52	F 684		

On 01/24/18 at 4:10 PM, Resident #100's electronic medication administration record (MAR) was reviewed. The MAR included Travoprost solution 0.0004% eye drops to be administered in both eyes at bedtime, but did not include the Dorzolamide-timolol 2-0.5% per the hospital discharge medication list.

On 01/25/18 at 12:47 PM, the above finding was shared with the East unit manager. The unit manager stated the resident was originally admitted to the West unit and that he would clarify the eye drop orders.

On 01/25/18 at 2:58 PM, the clinical record was reviewed. A progress note authored by the East unit manager dated 1/25/18 timed at 1:09 pm read, "resident Dorzolamide-timolol to start due to resident being on it prior to admission med was ordered upon discharge (from hospital) and verified but was not added to the MAR (medication administration record) explained to (attending physician name) that resident hasn't had med since before admission and he stated to start Dorzolamide-timolol and to start liquid tears resident son (name) also made aware of the situation and was thankful for call to him and MD and also made family aware that if there were any problem that they needed to be addressed my door is always open."

On 01/25/18 at 3:17 PM, the record evidenced a physician orders read dated 1/25/18: 1. Cosopt PF Solution 22.3-6.8 mg/ml (Dorzolamide HCL) instill 1 drop in both eyes two times a day for glaucoma. 2. Artificial tears solution 1.4% instill 1 drop in both eyes as needed for dry eyes.

On 01/25/18 at 3:31 PM, the East unit manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 53	F 684		

was interviewed and stated the hospital discharge medications were verified on admission with the attending physician. He further stated "It (the order for the Dorzolamide-timolol eye drop) was verified but not keyed into the system."

On 1/26/18 at 11:05 AM, the above findings was shared with the Administrator, the DON (Director of Nursing) and the Assistant DON during the pre-exit meeting.

2. Resident #94 was admitted to the nursing facility on 10/25/11 with diagnoses that included hypertensive end stage renal disease on dialysis.

The most recent Minimum Data Set (MDS) was dated 12/27/17 and coded the resident on the Brief Interview for Mental Status for Mental Status with a score of 9 out of a possible 15, which indicated the resident was moderately impaired in the skills needed for daily decision making.

The care plan dated 12/29/17 identified that the resident had poor intake and required supplemental support and they were to be administered per physician's orders.

Resident #94 had physician's orders dated 5/10/17 for B complex with folic acid.

On 01/17/18 at 12 p.m., the B complex with Folic acid was not available to administer. Licensed Practical Nurse (LPN) #10 stated he had given it the day before and it was in a white bottle and it was a house stock. He checked all units for the B complex from the house stock, which he was unable to locate. At 12:15 p.m., LPN #9, who had administered medications for Resident #94 before said, "We have been giving the plain B complex without folic acid since the day it had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 54 been ordered and we should have clarified the order. We have never given B complex with folic acid, but plain B complex." The East Wing Unit Manager LPN #2 and the Assistant Director of Nursing (ADON) stated they would contact the Family Nurse Practitioner (FNP) to separate the med if it did not come in one pill form. On 1/26/18 at 11:05 a.m., a pre-exit meeting was conducted with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). The DON stated he expected physician's orders to be followed and if there were problems in obtaining an ordered medication, the nurse should obtain clarification with the physician.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure adequate supervision and assistance devices were used to prevent an accident for 1 of 34 residents in the survey sample, Resident #78. Resident #78 was incorrectly transferred by pivot to stand, instead of two person Hoyer lift,	F 689	1. Staff educated to use total lift for resident #78. 2. All residents have the potential to be effected by this practice. 3. Unit Managers or designee will educate CNAs on following correct transfers for residents which is shown on Kardex. New hires will be required to complete Transfer competency to include patient specific	3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 55 resulting in a fracture of her knee. The findings included: Resident #78 was initially admitted to the facility on 9/24/14. Diagnoses listed for Resident #78 included but not limited to Alzheimer's Disease, Arthritis, Osteoporosis and Fracture. Resident #78's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date of 12/8/17, coded Resident #78 as scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) cognitive impairment. The resident was completely dependent on two staff for bed mobility, transfers and toileting. The resident's balance was assessed as not steady, and only able to stabilize with staff assistance for balance during transfers. The Comprehensive Person Centered Care Plan dated 6/1/16 identified the resident required total assistance with ADL (Activities of Daily Living) functioning d/t (due to) Alzheimer's, psychosis, dementia, visual impairment, osteoarthritis and pain. The goal was "She will have ADL's met daily through next review." One intervention listed to achieve the goal was to transfer with total assist of two staff using a total lift. Resident #78 was at also identified at risk for falls related to decreased mobility, weakness, short and long term memory deficit, impaired vision (prefers to remain in bed for comfort ...only gets up once-twice a week). One intervention included call bell within reach. The goal was "She will have no preventable injury from falls thru next review." The care plan updated on 11/15/17 documented, Right Tibia Plateau fracture with the goal of "Will	F 689	Kardex before orientation is complete. 4. Unit manager, or designee, will audit 1-2 random resident transfers daily for three months and then weekly for one month. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 56	F 689		

have maximum functional mobility." Interventions: Included but were not limited to: Leg brace on and off per MD (Medical Doctor's) orders; Monitor Pain; Ortho follow up as needed; Circulation checks to affected limb.

The Comprehensive Person Centered Care Plan dated 6/1/16

The CNA (Certified Nursing Assistant) Kiosk (a computer station CNAs use to document and see the Resident's assessed needs) documented on Page 3 of 3: ADL (Activity of Daily Living) Section: Transfers with total assist of two using total lift.

The Kardex Report printed 1/24/18 and received on the same date at approximately 11:35 AM, documented the following: ADL: Transfers with total assist of two using total lift.

A Facility Reported Incident received on 11/14/17 at the State Agency. The report stated the resident was found with an injury of unknown origin. An x-ray was obtained and confirmed a potential tibial fracture.

The facility's investigation of the injury of unknown origin concluded, based on the results of the investigation, "we determined the hairline fracture occurred during a bed transfer via total mechanical lift. The lift was used appropriately with two CNAs present. We believe when the resident was in the lift and being transferred from the bed to chair, her leg remained in contact with the mattress, potentially putting pressure at the knee and causing the hairline fracture."

Further record review evidenced the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 57 11/14/17 X-Ray Report: Knee Results: No previous studies are available for comparison. There is a depressed fracture of the medical tibial plateau which appears new. The knee joint is significantly narrowed. Conclusion: Findings are consistent with an acute fracture involving the medial tibial plateau. Addendum: There is proximal tibial shaft medical subcortical hairline fracture without displacement. An 11/16/17 Nurse Practitioner #4 note documented the following: "(Resident #78) is a recent Tibial Plateau fx (fracture) to R (Right) leg. She states the knee was caught in a chair. She was seen by (Orthopaedic and Spine Specialist) today and knee Immobilizer with padding - has FU (follow up) in 2 wk's (weeks) 11/20/17... A/P (Assessment/Plan) 1. R (Right) Tibial Plateau fx (fracture) - Keep knee immobilized. Skin/vascular (checks) q6h (every six hour) while awake. Rx (Prescription for Norco 5-325 mg, 1 po (by mouth) BID (twice daily)..." Resident #78's 11/16/17 Orthopaedic and Spine Specialist note documented the following: "CC: (Chief Complaint) Right Knee Pain HISTORY: (Resident #78) is 87 y.o. (year old) female who is seen for right knee pain. She first complained of pain on 11/14/17 after her knee got caught on a chair at (Facility) while getting her hair done. She had right knee x-rays at (Facility) on 11/14/17 that revealed a medical plateau fracture...History is somewhat lacking and unreliable due to non verbal state. Her daughter is present today. She has not walked since her	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 58 great toe amputations 4 years ago by ... She is hypertensive. She has a h/o (history of) peripheral vascular disease... Physical Exam: Range of motion: Unable to test due to pain Pt. (Patient) wearing a knee immobilizer. She is non-ambulatory on a stretcher. Patient is non-verbal on today's exam. RADIOGRAPHS: RIGHT KNEE: 11/16/17 Impression: Three views - Fracture of the medical tibial plateau, no effusion, complete joint space narrowing, + (plus) osteophytes present. RIGHT KNEE 11/14/17 Impression: Findings are consistent with an acute fracture involving the medial tibial plateau. IMPRESSION: 1. Closed fracture of medical portion of right tibial plateau, Initial encounter 2. Acute pain of right knee 3. Amputated great toe of left foot 4. Amputated great toe, right 5. Equinus contracture of ankle 6. Peripheral vascular disease 7. Primary oseteoarthritis of right knee severe. PLAN: She will be placed in a well padded knee immobilizer today. Pressure sore precautions provided. She will follow up two weeks. There is no need for surgery at this time. Instructions for skilled care facility provided today." During review of the facility investigation, staff statements revealed the following: CNA #20 documented that she cared for	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 59	F 689		

Resident #78 on 11/11/17 and "she did not complain of any pain during care."

CNA #21 documented that Resident #78, "didn't complain of any pain during AM care on 11/9/17 or 11/10/17. On 11/9/17 after doing ADL's I got (Resident #78) dressed and up into her chair, and still there were no complaints of pain. Her daughter and son-in-law came to visit her on 11/9/17 and I left her sitting up in the chair with her family. I also had (Resident #78) on 11/10/17 I performed ADL care and (Resident #78) still never complained of any pain. I didn't get her up on Saturday 11/10/17 because she didn't' want to get up because she was up the day before."

A statement taken from Resident #78's daughter and documented by the Unit Manager #1, dated 11/14/17 at 2 PM documented the following: "...she was here on 11/9/17 to visit her mother. She stated that she (Resident #78) did not complain of any pain during the visit. There was nothing different with her while visiting."

CNA #22 documented the following: "... I (CNA #22) had (Resident #78) on 11/12/17. She didn't complain about pain while doing her ADL care and second rounds."

CNA #23 documented the following: "To whom this may concern, on 11/13/17, I (CNA #23) assisted (CNA #7) with patient transfer via hoyer lift bed ... After transferring patient had no complaints."

In addition to the above 11/14/17 dated staff statements, an undated and unsigned statement from the Social Worker #2, was reviewed. The Social Worker documented: (Resident #78)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 60	F 689		

"BIMS Score completed with (Resident #78), She Scored 3/15. When asked what happened to her leg she was unable to give a complete story. Social Services asked (Resident #78) what happen she stated she didn't want to go to dinner and she stayed in bed. She was then asked did she get up and fall, she stated she is unable to walk. She then pointed to her chair stated is (it) was not stretched out enough. (Resident #78) continued to state it was the bottom of the chair. When asked did her leg get caught she would not answer. When asked did she sit on it she would not answer. When asked how much pain she was in and where the pain was she stated in her right leg and only hurts when she moves it."

Review of an 11/16/17 document from the Administrator documented the following: "On Tuesday, November 14, 2017 resident complained of pain in her leg and resident's right knee noted to be edematous. An X-Ray was ordered and taken. X-Ray results showed a right Hairline tibial fib fracture, Resident denied any further pain. Call placed to the MD and ...NP ordered a leg immobilizer and ortho f/u. Administrator made aware of results and an investigation began. F.R.I. completed on 11/14/17. Spoke with CNA's who provided care to Resident dating back from 11/9/17. Interviews with (CNA #24, CNA #21, CNA #22, CNA #7, CNA #25, CNA #26, CNA #20 and CNA #23). Upon interviewing these individuals, it was noted that (Resident #78) did not complain of any pain while receiving care until 11-14-17. Resident has scheduled Norco 5-325 mg (milligrams) BID (twice daily) and a PRN (as needed) Norco 5-325 mg q4h (every 4 hours). Daughter...was made aware in the process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 61	F 689		

Information gathered from the above mentioned staff members and narrowed down to two individuals. After speaking with (CNA #7 and CNA #23) with role play return demonstration, it was concluded that poor procedure was used when transferring resident into geri chair. Policy and practice was followed per total lift use. However resident's bed was positioned in such a way as the residents legs were slightly dragging on bed when resident was removed from the bed via lift.

With this information we have determined the resident's body left the bed before her feet potently (potentially) causing the hairline fracture. No deficient practice noted during return demonstration however we will be in servicing on observing leg placement while using Hoyer lift."

A document dated 1/19/1 by the Facility Administrator #1, written to clarify his 11/16/17 document statement of "poor procedure" documented the following: "As a clarification to my previous statement of "poor procedure was used," this was intended to highlight the potential issue when using the total lift and the need to educate. The CNA's use of the lift at the time was in accordance to the training materials provided to them. The training material does not mention the need to lower the bed once the resident is secured in the lift."

Review of a 11/17/17 letter sent to the State Agency, from the Administrator to follow up the 11/14/17 Injury of Unknown Origin FRI documented the following: "... An investigation was completed to included interviews with the resident, staff members and a clinical record review. Based on the results of the investigation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 62	F 689		

we determined the hairline fracture occurred during a bed transfer via total mechanical lift. The lift was used appropriately with two CNA's present. We believe when the resident was in the lift and being transferred from the bed to to chair, her leg remained in contact with the mattress, potentially putting pressure at the knee and causing the hairline fracture. No deficient practice noted during return demonstration however, we will be in-servicing on observing leg placement while using mechanical lift. Resident has no complaints of pain and is being followed by Ortho with no new orders noted at the time."

Review of Physical Therapy Evaluation and Plan of Treatment dated 12/5/17 documented the following:
Reason for Referral: "... referred to PT (Physical Therapy) by nursing due to pressure ulcer development secondary to R (Right) extension brace. Reason for Therapy: Reason for Skilled Services: Patient requires skilled PT services to in order to enhance patient's quality of life by improving ability to decreased risk of additional wounds. Long Term Goals: CNA staff will be educated on positioning RLE (Right Lower Extremity) for decreased risk of additional pressure ulcers."

Review of a document given by the DON on 1/19/18 at approximately 10:05 AM, documented a timeline of Resident #78's fall. This document was not dated and was not signed. The DON reviewed the documented information on the 1/19/18 document at approximately 10:05 AM. The document regarding the incident included the following:

Fall:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 63 11/14/17 resident c/o (complained of) pain in leg, right knee noted to be edematous 11/14/17 resident medicated for pain with no other c/o pain on 11/14/17 11/14/17 x-ray completed with result of hairline fx (fracture) of tib (tibia), fib (fibula). 11/14/17 M.D. (Medical Doctor) aware of x-ray results order for immobilizer placed and Ortho f/u (follow up) 11/14/17 Administrator made aware, investigation started, F.R.I. completed 11/14/17 Interviewed C.N.A.s providing care dating back from 11/9/17, resident did not complain of pain before 11/14/17 11/14/17 from staff interviews we narrowed investigation to two staff members. (CNA #23 and CNA #7) 11/15/17 second interview including role play with physical demonstration revealed cause of fx. (fracture). Staff members had resident in total lift when resident buttocks left bed causing increased pressure to legs that were still on bed. 11/16/17 Ortho appointment confirmed fx (fracture) Review of the education attendance logs done post fracture given by the ADON (Assistant Director of Nurses) on 11/20/18 regarding fall Protocol had CNA #23's signature but did not include CNA #7's signature. Review of CNA #23's employee file included a document for "Resident Handling Competencies", dated and signed 12/19/17. Review of CNA #7's employee file included a document "Employee Acknowledgement of Receipt of Fraud and Abuse Policy" dated and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 64	F 689		

signed 9/27/17. Review of CNA #7's employee file also included a documented dated and signed by CNA #7 on 9/27/17 that he had received, read, and understood the following policies: Safe Resident Transfer Policy. Review of CNA #7's employee file documented that he was removed from the payroll effective date 11/21/17 for insubordination.

A documented received by the Director of Rehabilitation on 1/24/18 at approximately 11:28 AM, of staff that had signed for education done 9/27/17: Topic: Resident Handling New Hire/Quarterly, included CNA #7's name and signature.

An observation was made of Resident #78 on 01/16/18 at approximately 10:45 AM during the initial tour. Resident #78 was lying in bed, eyes closed, Geri chair in room, air mattress on bed. Resident #78 was observed well-groomed and with no odor.

Another observation was made on 1/26/18 at approximately 11:00 AM, of CNA #2 with two other CNA's in the room, the Hoyer Lift in room, and Resident #78 sitting in her Geri Chair. Resident #78 stated, "Come in" very softly. CNA #2 stated that Resident #78 was getting up for lunch. Resident #78's Right leg immobilizer splint was observed to be on.

On 1/19/18 at approximately 12:30 PM, an interview was conducted with the Director of Nurses (DON) #2, the Administrator #1, and the Regional Clinical RN (Registered Nurse) #4. The Regional Clinical RN stated that the 2 CNAs involved performed the procedure correct per their investigation. The Administrator was asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 65	F 689		

to clarify his statement "poor procedure was used" and he stated that he meant "due to fracture during transfer" and was asked to write another document explaining his intention/meaning of the words.

The group was asked if a Corrective Action Plan was done and the Regional Clinical RN stated: "No, it wasn't as we felt there was not a deficient practice." The Administrator #1 stated that his investigation showed that Resident #78's pain began on 11/14/18 and the facility investigation felt it was related to the 11/13/17 transfer of two CNA's (CNA #7 and CNA #23). The DON was asked if the fracture was caused by a fall as documented on the timeline form. The DON stated that Resident #78 did not fall.

On 1/19/18 at approximately 10:05 AM, the DON #2 stated that Resident #78's pain started on 11/14/17. The DON was asked for an employee statement from CNA #7 as it was not included in the group of employee statements.

On 1/19/18 at approximately 1:30 PM, the DON along with CNA #27 and LPN (Licensed Practical Nurse) #2 performed a simulation of a transfer using a Hoyer lift. The DON stated that he felt that during transfer the Resident's leg may have bumped back into the mattress as the resident's leg was coming off the mattress.

On 1/19/18 at approximately 2:45 PM, CNA #23 was interviewed. CNA #23 stated that she was asked to help by CNA #7 for the transfer. CNA #23 stated she had hands on bar of lift, the bed was raised, as she was pulling back, CNA #7 was assisting the patient. CNA #23 was asked if Resident #78 started complaining of pain during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 66	F 689		

the transfer, or if she saw the resident's legs hit or get stuck during the transfer. CNA #23 stated: "Not that I remember." CNA #23 stated that staff were in-serviced about being mindful of objects surrounding, to always use two people and to immediately report any pain the resident may have. CNA #23 was asked if there is a document on the inside of the Resident's closet door that states how a resident is to be transferred. CNA #23 stated, "No." CNA #23 stated that she was involved in a re-enacted role-play of transfer with a Hoyer lift. She stated that CNA #7 was not involved in the role-play as he was off on 11/14/17.

On 1/19/18 at approximately 1:30 PM the Facility Administration produced the Video, titled "Proper Body Mechanics and Mechanical Lift Training" that the DON stated was used to orient new CNAs on use of lift. The video was progressed to the portion related to Hoyer lift transfers. The surveyor observed this portion of the video. A copy of a slide that correlated to the Video was provided to the Surveyor. It documented steps of a sling transfer.

On 1/23/18 at approximately 10:48 AM, Resident #78's daughter was called. The daughter stated that she was notified of the fracture and she recalled on the day that she had requested that her mother be gotten up so that she could go to the beauty parlor. The daughter was not in the room when Resident #78 was gotten out of bed.

On 1/23/18 at approximately 4:16 PM, CNA #7 was called by phone, by the Administrator with the DON and survey team present. After introductions of all present in the room, CNA #7 was asked to explain what happened as he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 67	F 689		

caring for Resident #78 on 11/13/17. CNA #7 stated that he had to have all his residents up before lunch. CNA #7 stated that he was in the room performing ADL care on Resident #78 and he needed help to get her out of bed. He stated he asked CNA #23 to help. When asked how Resident #78 was gotten out of bed, CNA #7 stated that he did a Pivot to stand transfer. CNA #7 stated that Resident #78 had complained of hurting before the 11/13/17 transfer. CNA #7 stated that he was on the Resident's Right side while CNA #23 was on the Resident's Left side. CNA #7 stated they put their arms under the Resident's arms and stood her and placed her in the chair. CNA #7 stated he thought there was pressure on the Resident's legs. CNA #7 stated that the next day (11/14/17) he was off. CNA #7 stated on 11/14/17 he received a call from the DON and was informed that Resident #78's leg might be broken.

CNA #7 stated during the phone interview that on 11/15/17 when he returned to work, he was informed that the DON wanted to talk with him. CNA #7 stated that the conversation included the Unit Manager #1, LPN #1, the DON #2 and himself CNA #7. CNA #7 stated that the DON asked him what happened, and encouraged him to tell the truth. CNA #7 stated that he told them that he did not use the Hoyer lift when he transferred Resident #78 on 11/13/17. Then CNA #7 stated that he did not receive a verbal warning or a written statement regarding the transfer. CNA #7 stated that he did do a witness statement and gave it to the DON. CNA #7 did not keep a copy of his witness statement. Neither the Administrator nor the DON recalled the specifics of CNA #7's missing Witness Statement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 68	F 689		

During the phone conversation with CNA #7, as he stated he did not use the Hoyer Lift, the Administrator and DON were observed shaking their heads from left to right as in a no response.

The Administrator was asked about the cause of the fracture. The Administrator stated that the conclusion was when removing the Resident from the bed her feet had contact with her bed.

After the phone call, both the Administrator and the DON stated that CNA #7's statement was not what he had told them previously. Both the Administrator and the DON stated that they have not found a copy of CNA #7's written statement. When asked why CNA #7 was not included in the education that was done for the facility, the DON stated that CNA #7 did not work on 11/14/17 and was terminated soon after. The Administrator stated that it was the Facility's conclusion based on information they had received during their investigation, was that the fracture cause was related to the lift. The Administrator was asked if as the Administrator if he had seen CNA #7's Witness statement. The Administrator stated he spoke with him and was never told that the transfer did not occur in any way other than by the Hoyer lift.

The Social Worker's written statement was read by another surveyor and commented that the document was neither dated nor signed. On 1/25/18 at approximately 2:45 PM, the Social Worker when asked when she wrote her document, went into her document history and pulled up the same document to show that it was written on 11/14/17 at 4:18 PM.

The Administrator stated: "We can't be having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 69	F 689		

this. That's going to change." The Administrator also stated, "This building had a history of covering up." When asked for clarification none was given. The Administrator on 1/23/18 at approximately 4:56 PM, stated that he constantly tells staff if they feel they are not heard they can go above him and call the Hot Line Number. The Administrator stated that if he (CNA #7) was told to do something fraudulent he should have come to him or called the hot line number.

On 1/23/18 at approximately 6:15 PM, the Regional Clinical RN stated that after the incident of Resident #78's fractured leg, the facility identified that a second CNA will be used to guide the legs during a Hoyer lift transfer. She stated, "We didn't identify a deficient practice, so we didn't do a Corrective Action Plan. The Administrator was informed that the Policy and Procedure of Hoyer Lift #8 stated: "Provide Support" and the Administrator stated that there are many ways of support, and that the word support doesn't just mean hands on support. He stated it could also mean emotional support during the transfer.

On 1/25/18 at approximately 11:48 AM, CNA #23 was interviewed again. CNA #23 was informed that on 1/23/18 a meeting with the DON, the Administrator and CNA #7 on phone along with the State Surveyors was conducted. CNA #23 was informed that CNA #7 had stated that he did not use a Hoyer lift during transfer of Resident #78. CNA #23 was asked if she would like to amend or to change her previous written witness statement. CNA #23 was silent for a few moments. CNA #23 was asked again if she wanted to amend or change her previous statements of using a Hoyer lift with CNA #7 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 70	F 689		

1/13/18. After a few more moments, CNA #23 stated that CNA #7 put his arms under the Resident's arms and lifted her and then twisted her into the Geri Chair. CNA #23 stated that she felt influenced to say she assisted in a Hoyer Lift transfer as it was the correct way that Resident #78 was to be transferred. CNA #23 was heard by three Surveyors to say prior to her exit from the conference room, "I'm sorry; I should not have done that."

The Facility Policy and Procedure titled, "Incident/Accident Report" with a revision date of February 2016, documented the following:
Section 6. Witness statements: a. Witnessed incident/accident - The nurse will immediately begin collecting witness statements from any staff, family member, visitor and/or other residents that witnessed incident/accident.

The Facility Guidance given to the surveyor from the Administrator titled, "Transfer Techniques" without a date and without a reference, documented the following:
Responsibility: Therapist
Before initiating treatment, the patient/resident is evaluated by the therapist to determine appropriateness and method of transfers to be utilized.
Staff to know patient/residents diagnosis and/or precautions
Apply Gait/transfer belt as determined by Therapist: Recommended if patient/resident requires physical assistance greater than 25% of task and position of belt does not compromise respiratory status, incisions, IV's etc
Explain entire procedure to patient/resident.

The DON stated on 1/26/18 at approximately 2:45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 71 PM, that he could not find any guidance for stand pivot transfers for CNA use. The DON stated that it was his expectation that if a stand pivot transfer was used, that a gait belt should be used and that the resident be able to pivot. The DON stated that Resident #78 was not able to pivot. The Facility Policy and Procedure titled, "Personal Care" with a Revision date of July 2015, documented the following: Policy: A mechanical lift may be used for moving residents that cannot safely move by themselves and are too heavy to be safely lifted by one or two assistants. Number 8 documented, "Guide the resident away from the bed with one staff member supporting the resident and one manipulating the lift." The facility administration was informed of the findings during a pre-exit conference on 1/26/18 at approximately 11:05 AM and again during the Exit Conference on 1/26/18 at approximately 3:30 PM. The facility did not present any further information about the findings.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure 1	F 697	Past noncompliance: no plan of correction required.	3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 72	F 697		

resident of 34 residents in the survey sample received pain management in a timely manner, Resident #301.

The findings included:

Resident #301 was admitted to the facility on 8/28/17 after a 3 day hospital stay. Diagnoses listed for Resident #301 included but not limited to Spinal stenosis at Lumbar 4 through 5 level and Lumbar radiculopathy. Resident #301 left the Nursing Facility against medical advice on 8/29/17.

Record Review documented Resident #301 was admitted on 8/28/17 19:38 (7:38 p.m.)

The 8/28/17 7:30 p.m. Admission Assessment documented: Evidence of Pain (Yes), Pain History: (back pain), Pain site (lower back), Description of pain: (Chronic), Frequency of Pain: (once in a while in response to stimuli), Aggravating factors (some movement), Relieving factors (pain medication), Patient Pain Rating: (6 of 10). Resident identified facial pain scale to be "Hurts a little bit".

The Admission Assessment documented Resident #301 was awake, alert, and oriented to person place and time.

The Comprehensive Person Centered Care Plan dated 8/29/17 identified the resident had a Focus Area of "Pain". The goal included, "Will maintain comfort to highest degrees possible." Several interventions included, administer pain medication as ordered, assess for pain every shift, and monitor for pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 73	F 697		

On 1/24/18 01/24/18 at approximately 02:12 PM the DON (Director of Nursing) when asked what his expectation would be if a resident complained of a Scale 6 pain during admission. The DON stated he would check when the Resident last had pain medication in the hospital, and if appropriate would administer pain medication. Requested copy of Resident's report to inquire when she last was given pain medication at the hospital.

The DON provided a document titled (Nursing Admission Report) documented Last medicated 8/28/17 1600 (4 p.m.)

Resident #301's Medication Administration Record documented she was first administered pain medication (Prescribed 8/28/17 Acetaminophen Tablet 325 milligrams Give 2 tablet every 4 hours as needed for mild pain) on 8/28/17 at 11:32 PM for reported pain level of 8 of 10 and documented as effective. Resident was also prescribed on 8/28/17 Hydrocodone-Acetaminophen Tablet milligram Give 1 tablet by mouth every 4 hours as needed for pain and the August 2017 MAR documented this being first administered on 8/29/17 at 1202 (12:02 PM) for a pain level of 6 of 10.

A letter dated 12/1/17 and signed by the Director of Nursing indicated that HQI (Health Quality Indicators) brought to the attention an occurrence of a new admission not receiving scheduled narcotic for pain relief in a timely manner. The letter indicated the allegation was investigated and concluded the resident did have a delay in medication administration due to a lack of a prescription at the time of admission. The letter continued to document, that the resident arrived

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 74	F 697		

at the facility without a hard script from the discharging Hospital. Without this script there would be a delay due to the need for our attending physician to assess and the pharmacy to fulfill the order. Due to the admission arriving in the evening hours the end result was the pharmacy not being able to fill medication timely. We have since educated our staff on the process of obtaining medications from the emergency medication box. In addition we have also partnered with a new physician group that will provide greater in house coverage to prevent further delays in hard scripts.

An undated document, titled "Plan of Correction: Timely Pain Management on Admission with a date of compliance 12/5/17 documented the following.

1. No correction to be made related to resident no longer in facility.
2. Residents who are admitted with narcotic pain orders are at risk for this issue.
3. Unit Managers will be inserviced by the DON regarding narcotic medications ordered on admission. This will include:
Requiring a written, complete and signed prescription from discharging physician. If prescription is not sent to facility, call attending physician and obtain the prescription. If medication has not arrived from the pharmacy the nurse will contact the attending physician and get an order for a "one time dose" of the narcotic and remove medication from the STAT (emergency box of medications) box.
4. DON or designee will randomly audit new admission orders containing a narcotic order for: prescription obtained delay in obtaining pain medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 75	F 697		

for 6 months and audit results will be shared in QAPI (Quality Assessment Performance Indicators) meetings.
5. Date of compliance 12/5/17

A Record of In-Service dated 12/4/17 documented the Facility's two Unit Managers were educated on the following:

New Admit Medication Review
Timely Narcotic acquisition
STAT Box Narcotic acquisition

The Resident was admitted on 8/28/17 at 7:38 PM and did not receive a 8/28/17 Physician prescribed, Hydrocodone-Acetaminophen Tablet milligram Give 1 tablet by mouth every 4 hours as needed for pain until approximately 16 hours after admission. The August 2017 MAR (Medication Administration Record) documented this being first administered on 8/29/17 at 1202 (12:02 PM) for a pain level of 6 of 10.

The complainant on 1/16/18 at approximately 1:38 PM stated that her concerns were that she did not get her narcotic pain medication until day two of her admission. In addition, she stated that she wanted her narcotic medication to be given routinely and not as needed.

01/25/18 04:20 PM The DON stated that Resident # 301 should have received pain medication based on the initial 8/28/17 7:38 PM nursing assessment prior to 11:32 PM when Resident # 301 first received any analgesic upon admission.

The American Chronic Pain Association 2016 Resource Guide documented the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 76 guidance: In all persons, medication should be imitated at a low dose and adjusted slowly to optimize pain relief while monitoring and managing side effects. Multi-modal analgesia, which is the careful use of multiple pain-relieving drugs together, can be seen as potentially advantageous. Combining smaller doses of more that one medication may minimize the dose-limiting adverse effects of using a particular single drug. The facility administration was informed of the findings during a pre-exit conference on 1/26/18 at approximately 11:05 AM and again during the Exit Conference on 1/26/18 at approximately 3:30 PM. The facility did not present any further information about the findings.	F 697		
F 758 SS=E	COMPLAINT DEFICIENCY Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 77 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review, and facility document review, the facility staff failed to ensure an as needed (PRN) psychotropic drug was limited to 14 days, failed to monitor behaviors, and failed to implement behavioral interventions for 1 of 34 residents in the survey sample, Resident #79.	F 758	1. The facility has implemented behavior monitoring for resident # 79. Order for prn Xanax was changed to a routine order. The facility will contact physician regarding a dose reduction or documentation as to why it would not be appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 78 The findings included: Resident #79 was originally admitted on 8/18/14 and readmitted on 7/6/17 with diagnoses to include, but not limited to generalized anxiety, depression, and Non-Alzheimer's dementia. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 12/2/17 coded the resident as scoring an 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had moderately impaired cognition. During the seven day look back period the resident had received an antianxiety drug on each of the seven days (12/6/17-12/12/17). The Comprehensive Person Centered Care Plan initiated on 4/7/16 identified the resident had altered mood state "Anxious at times". The goal was that the resident will express/exhibit satisfaction. One of the goals listed the following interventions: assess, monitor and document mood, be reassuring and listen to concerns, redirect as needed, resident gets upset when other residents are being loud. An additional care plan dated 8/28/17 identified the resident had altered behaviors and/or mood related to dementia, anxiety, and non-compliance with care at times. The goal was that the resident would be free of behavioral outbursts and/or unusual behaviors daily. Several of the interventions listed to achieve the goal was to: administer medications as ordered by the physician and monitor for effectiveness, and report adverse reactions/ineffectiveness to the physician for further follow up.	F 758	2. All residents receiving psychotropic drugs have the potential to be effected by this practice. 3. Director of Nursing or designee, will in-service licensed nursing staff on transcribing and following physician orders, dose reduction and monitoring behaviors on residents with psychotropic medication. 4. Unit manager, or designee, will audit new orders weekly for three months and then random weekly for one month to ensure medications are transcribed correctly, behavior monitoring has been scheduled and dose reduction is set for the next 6 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 79	F 758		

The physician orders for the antianxiety drug (Xanax) were reviewed for the last six months. The orders were as follows:
1. Ordered on 7/17/17-Xanax tablet 0.25 mg (milligrams) 1 PO (by mouth) qhs (ever bedtime) PRN (as needed), 30 tablets with 5 refills.
2. Ordered on 12/20/17-Xanax 0.25 mg 1 tab as needed (PRN) at bedtime, 60 tablets.

The above PRN Xanax orders were not in compliance with the Federal regulation 14 day PRN psychoactive drug use as follows: PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

The facility pharmacy was called on 01/19/18 at 2:30 PM. Resident # 79's Xanax orders were reviewed with the pharmacist. The pharmacist indicated the Xanax order last received was on 12/20/17 and 7/17/17 were ordered PRN.

The current Controlled Medication Utilization Record had the correct order for the Xanax. The pharmacy label for the Xanax 0.25 mg read: Alpraxolam (generic name for Xanax) 0.25 mg take 1 tab by mouth as needed at bedtime. The control sheet evidenced the resident was administered Xanax 0.25 mg every night from 12/21/17 through 1/18/18.

Further investigation evidenced the facility failed to correctly input the data into the electronic MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 80	F 758		

(medication administration record). The Xanax order that was entered by the facility staff on 2/18/16 read: Xanax tablet 0.25 mg give 0.25 mg by mouth at bedtime for anxiety. The data entry was never corrected for the current orders.

The Order Summary Report which is part of the clinical record was also incorrect for the current Xanax orders dated 12/20/17. The entry read: Xanax tablet 0.25 mg (Alprazolam) give 0.25 mg by mouth at bedtime for anxiety, order date 2/18/16..

The MAR's from July 2017 through January 2018 were reviewed. The Xanax entry order for each of these months were incorrect. They were not changed/corrected according to the current physician PRN Xanax orders as noted above. The entries remained to administer the Xanax 0.25 mg at bedtime for anxiety and not PRN. Therefore, the resident was receiving the Xanax routinely every night from July 2017 through current.

There was no physician order to change the Xanax PRN order to a daily routine bedtime schedule from July 2017 to current 1/19/18.

The clinical record also failed to evidence a gradual dose reduction was recommended and/or trial for the Xanax from 7/17/17 through current. The clinical record evidenced the pharmacist reviewed the resident's drug regimen on 1/10/18 with no recommendations.

On 1/19/18 at 12:35 am, the licensed practical nurse (LPN#3) assigned to care for the resident was interviewed. She was asked if the resident had a Behavior/ Intervention Monthly Flow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 81	F 758		

Record for the Xanax. She reviewed the electronic record and stated, "No". She further stated she was not sure how to initiate one in the electronic record.

There was no documentation to evidence behaviors were monitored/ interventions utilized from 7/17/17 through 1/19/18. There was no documentation by the physician or physician designee for the PRN order to be extended beyond 14 days, or documentation of the rationale in the resident's medical record that indicated the duration for the PRN order.

On 1/19/18 at 4:24 PM, the East unit manager was interviewed. He was asked to read the current pharmacy label on Controlled Medication Utilization Record for the Xanax. The East unit manager stated the order as read is PRN. The East unit manager was asked to review the physician order, order was reviewed and read Xanax 0.25 mg by mouth at bedtime. Orders received from pharmacy evidenced the last physician order for Xanax 0.25 mg one tab as needed at bedtime was dated 12/20/17. UM to follow up with discrepancies.

During the survey days the resident was observed multiple times. He was observed inside his room, sitting up in a wheelchair, dressed appropriately either watching TV or eating meals. The resident was cooperative and pleasant during a conversation with this inspector on 1/7/18. He stated he prefers to stay in his room. No behaviors were observed during each observation.

On 1/23/18 11:00 AM, the East unit manager provided further information. He stated he had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 82	F 758		

spoke with the Nurse Practitioner (NP) to inform her of the medication error. The order was written as PRN, the order was entered incorrectly into the data system. The progress notes dated 1/19/18 read, "clarification talked to NP and explained that script and orders didn't match and resident was getting Xanax scheduled at bedtime instead of PRN at bed and NP stated to keep giving resident med scheduled at bedtime and that she would fax new script to pharmacy to match orders." He stated the NP would be in to assess the resident tomorrow.

On 1/24/18 at 2:36 PM, the Nurse Practitioner was interviewed. She stated the resident was new to her and she had only seen him once. She stated the order for the Xanax she wrote on 12/20/17 was given during an onsite visit. The notes read, in part : PSYCH: Nml (normal) Mood/affect; cooperative; not anxious; not agitated. Assessment /Plan (reviewed with patient/: 1) Anxiety_Chronic, stable: renewed Xanax hard script written anf {sic} given to nurse. The order was written as Xanax 0.25 mg (milligrams) 1 tab as needed at bedtime. The NP stated that when the facility called her on 1/19/18 to notify her of the medication error she directed the staff to continue to administer the Xanax as scheduled and not to change it PRN (as ordered) to prevent potential withdrawal until she assessed the resident on the next visit.

The facility policy titled Psychotropic Medication Documentation and Review dated July 16, 2013 read, in part:
Policy- All resident receiving psychotropic medication will have their behaviors, effectiveness of interventions (pharmological and non-pharmacological) and potential for a gradual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 83 dose reduction of psychotropic medication monitored and documented. Procedure: A. Residents receiving psychotropic medication will have a Behavior/Intervention Monthly Flow Record (BFR) (Form 4.11) initiated on admission or whenever psychotropic meds are ordered. F. All residents receiving psychotropic medications will be reviewed, at a minimum, every quarter by the IDT (interdisciplinary) team to determine the effectiveness of the medication and interventions. On 12/26/18 at 12:35 pm, the Director of Nursing (DON) was interviewed inside his office. A copy of the BFR record policy was reviewed. The DON was asked if the resident was reviewed for the use of the Xanax per the facility policy. He stated, "He was not". On 1/26/18 at 11:05 AM, the above findings was shared with the Administrator, the DON (Director of Nursing) and the Assistant DON during the pre-exit meeting.	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations of medication pass and pour, clinical record review, staff interviews, and facility documentation, the facility staff failed to ensure they were free of medication errors of 5 %	F 759	1. Staff member pulled from nursing cart and educated. 2. All residents have the potential to be effected by this practice.	3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 84 or greater. Twenty Five opportunities for error were observed with 6 errors which constituted a 24 % medication error rate. The medication error involved Resident #150. The findings included: Resident #150 was admitted to the nursing facility on 7/24/13 with diagnoses that included Parkinson's Disease. The most recent Minimum Data Set (MDS) was a significant change in status assessment dated 12/5/17 and coded the resident with a score of 3 out of a possible 15 on the Brief Interview for Mental Status which indicated the resident was severely impaired in the skills needed for daily decision making. Resident #150 had the following physician's orders dated 2/17/16 for 10:00 a.m. administration: Aspirin 81 milligrams (mg), colace 100 mg, isosorbide mononitrate 30 mg, miralax 17 grams, refresh optive advanced solution 0.5-1-0.5%-1 drop in both eyes one time a day, gabapentin capsule 300 mg, Tylenol extra strength 500 mg and sinamet tablet 25 mg. A physician's order was in effect dated 2/23/16 to crush appropriate medications and may give with food or liquids as needed continuous. Nectar thickenened consistency liquids were ordered on 12/15/17. Even though the resident was placed on hospice services as of 11/17/17, he remained on his medications. On 1/17/18 at 10:00 a.m. during observation of medication pass and pour, Licensed Practical Nurse (LPN) #1 did not attempt to administers the aforementioned medications. The LPN did not	F 759	3. Director of Nursing or designee, will in-service licensed nursing staff on correct medication pass. Education and med pass audit will be complete on licensed nurse # 2. 4. Unit manager, or designee, will audit med pass on 1-2 licensed nurses weekly for three months and then weekly for one month. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 85	F 759		

crush any of the whole pill medications to place in a food substance to offer the resident, nor did he offer medications with nectar thickened liquids that were stored in a cooler on the resident's night stand. The LPN #1 stated, "He did not take his medications yesterday and I faxed the doctor to let him know, and I wrote a nurses note about this too." The LPN could not locate the fax that he was referring to, nor could he produce the nurses note that indicated he was having problems administering the resident his medications on the previous day (1/16/18). The LPN documented on the medication administration record that he was able to administer Resident #150 his medications on the previous day (1/16/18) and documented the resident refused his morning medications on 1/17/18 when it was observed by this surveyor none of them were offered to include eye drops for the resident to refuse.

On 1/17/18 at 11:00 a.m., a Certified Nursing Assistant (CNA) offered the resident 4 ounces of nectar thickened juice from the cooler and the resident consumed 100 %.

On 1/17/18 at 12:00 p.m., LPN #3 stated she had taken care of the resident in the past and administered medications crushed in applesause.

On 1/17/18 at 12:30 p.m., an interview was conducted with the East Wing Unit Manager, LPN #2. He stated he has previously offered the resident nectar thickened without difficulty without a straw. He also stated he expected LPN #1 to have crushed the resident's medication and placed them in pudding or applesauce with an attempt to administer them. He was not able to locate the fax that LPN #1 informed the physician he had not been able to give Resident #150 his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 86 medications on 1/16/18. In addition, the Unit Manager stated he expected LPN #1 to have told him he was not able to administer the resident's medications. The Unit Manager was made aware of the documentation entered by LPN #1 that he administered medications the previous day, 1/16/18 without difficulty which was directly the opposite of what he told the surveyor during the 10:00 a.m. medication pass observation on 1/17/18. On 1/26/18 at 11:05 a.m., a pre-exit meeting was conducted with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). The medication administration error rate was shared at this time. The facility's policy and procedures titled General Dose Preparation and Medication Administrator dated 1/1/13 indicated the staff should crush medications in accordance with pharmacy guidelines as appropriate and administer medications within ordered timeframes and observe the resident's consumption of the medications.	F 759		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, facility document review, and staff interviews, the facility	F 835	1. Corrected as worked schedule 2. All residents have the potential to be	3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 87 staff failed to administer the facility effectively and efficiently. As worked nursing schedules dated 8/16/17, 8/23/17, and 8/24/17 were inaccurate. The findings included: On 1/23/17 at 9:30 AM a phone interview was conducted with the complainant who was the previous Minimum Data Set (MDS) Coordinator #1. The MDS Coordinator #1 stated, "While an inspector was in the building in November I received a text message stating that my name was being forged on documents for dates that I was not even employed. My last day of employment with the facility was on 8/23/17 and I was on vacation from 8/16/17 through 8/22/17. When I returned from vacation on August 23, they terminated me. You can call the Name (MDS Coordinator #2) and ask her she also knows about it." On 1/23/17 at 10:15 AM a phone interview was conducted with MDS Coordinator #2. MDS Coordinator #2 was asked if she was aware of any documents that may have MDS Coordinator #1 name forged on them while she was not in the building or employed. MDS Coordinator #2 stated, "Yes, you need to look at the as worked nursing staff sheets for August, they were the ones you asked for when you were there doing that investigation in November." On 01/24/18 10:45 AM the as worked nursing staffing sheets were reviewed for the month of August 2017. The supervisor line was blank on the sheets that were provided for review for the dates 8/16/17, 8/23/17, and 8/24/17. However,	F 835	effected by this practice. 3. Director of Nursing or designee, will in-service Unit managers/Team leads on correct documentation of as worked schedules 4. DON, or designee, will audit as worked schedule daily for three months and then weekly for one month for accuracy. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 88	F 835		

this surveyor was in this facility on 11/14/17 and obtained the same dated as worked sheets for 8/16/17, 8/23/17, and 8/24/17 and in the supervisor line (MDS Coordinator #1's) name was written in on all 3 sheets and highlighted in yellow. The three original as worked nursing staffing sheets dated 8/16/17, 8/23/17, and 8/24/17 were obtained from the Office of Licensure and Certification.

On 01/24/18 10:50 AM an interview was conducted with the Payroll/Human Resources Manager. The Payroll/Human Resources Manager stated, "Name (MDS Coordinator #1) was on paid time off on 8/16/17 through 8/22/17. Employee returned to work on 8/23/17 and was terminated that same day.

Payroll documentation was obtained and reviewed which indicated that MDS Coordinator #1 was not in the facility on 8/16/17, 8/24/17, and was terminated on 8/23/17.

On 01/24/18 at 11:00 AM an interview was conducted with the Administrator and the Assistant Director of Nursing. They were asked if they were both present on 8/23/17 when the complainant was terminated and approximately what time of the day was she terminated. The Administrator stated, "Yes, and I'm not absolutely certain but I know she was not here the whole 8 hours." The Assistant Director of Nursing stated, "Yes, and I don't know the exact time but I think it was sometime between 11 am and 12 noon."

On 01/24/18 at 11:35 AM an interview was conducted with CNA#8, the Facility Scheduler. She was asked if it was her handwriting on the altered as worked schedules where (MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 89	F 835		

Coordinator #1's) name was written in and if so why did she add it. CNA#8 the Facility Scheduler stated, "Yes that's my handwriting and (Assistant Director of Nursing) told me to put her name there because we need a RN (Registered Nurse) in the building and we could use her." Surveyor asked if the ADON had given her any other RN name to use other than MDS Coordinator #1's and if she knew if MDS Coordinator #1 was even working on the days she added her to the as worked nursing schedule. CNA#8 the Facility Scheduler stated, "No, just (MDS Coordinator #1's) name and no I didn't check to see if she was actually here those days."

01/24/18 11:45 AM an interview was conducted with the ADON and she was asked if she had told the scheduler to use MDS Coordinator #1's name and no other RN on the as worked sheets when I was in the building on 11/14/17 and if she had checked to see if MDS Coordinator #1 even worked on the days her name was added. The ADON stated, "Yes I told her to use her name because it was either (Administrator) or (Director of Nursing) that told me to use her name because she was an RN and we could put her down and no I did not check to see if she had worked those day prior to telling the scheduler to add her name."

01/24/18 12:15 PM an interview conducted with the Administrator and the DON where the complaint was discussed and the above findings. The Administrator stated, "This is just embarrassing for us to have added a staff member that was not here on the days in question as well as on the 24th because she was terminated from the facility at that time."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 90 The facility Job Description for the Administrator was reviewed and is documented in part, as follows: Position Summary: To lead and direct overall operations of the nursing facility in accordance with Saber Health Care policies and procedures, customer and resident needs, and both State and Federal guidelines. To maintain excellent care for the residents/patients and achieve the facility business objective. Delegation of Authority: As the Administrator, you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties. You are responsible for carrying out the operational core responsibilities by the company and facility. You are all responsible for oversight of the resident care policies established by the facility. On 1/26/18 at 11:06 a.m. a Pre-Exit Conference was held with the Administrator, the Director of Nursing, and the Assistant Director of Nursing where the above information was shared. Prior to exit no further information was provided.	F 835		
F 842 SS=D	COMPLAINT DEFICIENCY Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 91	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 92 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record review, the facility staff failed to ensure the clinical record was accurate for 2 of 34 residents in the survey sample, Resident #79 and #150. 1. The MAR (Medication Administration Records) and the Order Summary Records were inaccurate for the PRN Xanax order for Resident#79. 2. The facility staff failed to ensure Resident #150's medical record was accurate. The findings included: 1. Resident #79 was originally admitted on 8/18/14 and readmitted on 7/6/17 with diagnoses to include, but not limited to generalized anxiety,	F 842	1. The order was corrected for resident #79 regarding the xanax and #150. 2. All residents have the potential to be effected by this practice. 3. Director of Nursing or designee, will in-service licensed nursing staff on transcribing and following physician orders. 4. Unit manager, or designee, will audit new orders weekly for three months and then random weekly for one month. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 93	F 842		

depression and Non-Alzheimer's dementia.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 12/2/17, coded the resident as scoring an 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had moderately impaired cognition. During the seven day look back period the resident had received an antianxiety drug on each of the seven days (12/6/17-12/12/17).

The Comprehensive Person Centered Care Plan initiated on 4/7/16 identified the resident had altered mood state "Anxious at times". The goal was that the resident will express/exhibit satisfaction. One of the goals listed the following interventions: assess, monitor and document mood, be reassuring and listen to concerns, redirect as needed, resident gets upset when other residents are being loud.

An additional care plan dated 8/28/17 identified the resident had altered behaviors and/or mood related to dementia, anxiety, and non-compliance with care at times. The goal was that the resident would be free of behavioral outbursts and/or unusual behaviors daily. Several of the interventions listed to achieve the goal was to: administer medications as ordered by the physician and monitor for effectiveness, and report adverse reactions/ineffectiveness to the physician for further follow up.

The physician orders for the antianxiety drug (Xanax) was reviewed for the last six months. The orders were as follows:
1. Ordered on 7/17/17-Xanax tablet 0.25 mg (milligrams) 1 PO (by mouth) qhs (ever bedtime)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 94	F 842		

PRN (as needed), 30 tablets with 5 refills.
2. Ordered on 12/20/17-Xanax 0.25 mg 1 tab as needed (PRN) at bedtime, 60 tablets.

Further investigation evidenced the facility failed to correctly input the data into the electronic MAR (medication administration record). The Xanax order that was entered by the facility staff on 2/18/16 read: Xanax tablet 0.25 mg give 0.25 mg by mouth at bedtime for anxiety. The data entry was never corrected for the current orders.

The Order Summary Report, which is part of the clinical record, was also incorrect for the current Xanax orders dated 12/20/17. The entry read: Xanax tablet 0.25 mg (Alprazolam) give 0.25 mg by mouth at bedtime for anxiety, order date 2/18/16.

The MAR's from July 2017 through January 2018 were reviewed. The Xanax entry order for each of these months were incorrect. They were not changed/corrected according to the current physician PRN Xanax orders as noted above. The entries remained to administer the Xanax 0.25 mg at bedtime for anxiety and not PRN. Therefore, the resident was receiving the Xanax routinely every night from July 2017 through current.

There was no physician order to change the Xanax PRN order to a daily routine bedtime schedule from July 2017 to current 1/19/18.

On 1/19/18 at 4:24 PM, the East unit manager was interviewed. He was asked to read current pharmacy label on Controlled Medication Utilization Record for the Xanax. The East unit manager stated the order as read is PRN. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 95	F 842		

East unit manager was asked to review the physician order, order was reviewed and read Xanax 0.25 mg by mouth at bedtime. Orders received from pharmacy evidenced the last physician order for Xanax 0.25 mg one tab as needed at bedtime was dated 12/20/17. UM to follow up with discrepancies.

On 1/23/18 11:00 AM, the East unit manager provided further information. He stated he had spoke with the Nurse Practitioner (NP) to inform her of the medication error. The order was written as PRN, and the order was entered incorrectly into the data system. The progress notes dated 1/19/18 read, "clarification talked to NP and explained that script and orders didn't match and resident was getting Xanax scheduled at bedtime instead of PRN at bed and NP stated to keep giving resident med scheduled at bedtime and that she would fax new script to pharmacy to match orders."

On 1/26/18 at 11:05 AM, the above findings was shared with the Administrator, the DON (Director of Nursing) and the Assistant DON during the pre-exit meeting.

2. Resident #150 was admitted to the nursing facility on 7/24/13 with diagnoses that included Parkinson's Disease.

The most recent Minimum Data Set (MDS) was a significant change in status assessment dated 12/5/17 and coded the resident with a score of 3 out of a possible 15 on the Brief Interview for Mental Status which indicated the resident was severely impaired in the skills needed for daily decision making.

On 1/17/18 during the 10:00 a.m. medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 96 pass and pour, Licensed Practical Nurse (LPN) # 10 said he would not be able to administer the resident his medications and further stated, "I faxed the physician, and documented on the Medication Administration Record (MAR) on yesterday (1/16/18), as well as the nurses's notes that I was not able to give him his medications and I called the physician. I will fax him again now". The MAR dated 1/16/18 indicated LPN #10 administered all the resident's medications. Additionally, there were no nurse's notes that confirmed LPN #10 was not able to administered the medication on 1/16/18 or that the physician was informed of the situation. On 1/17/18 at 11:00, a.m., the LPN #2 Unit East Manager was informed of the aforementioned documentation issue. He checked the nurses' notes and could not confirm what LPN #10 said, nor could he find the fax or verify the physician was informed of the difficulty with administration of medications. On 1/26/18 at 11:05 a.m., a pre-exit meeting was conducted with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). They were informed of the documentation issue and stated they expected documentation to reflect accuracy in care for the resident. The DON stated LPN #10 was taken off the cart for other reasons, but he was not informed by the Unit Manager of the discrepancy in documentation. The facility did not have a facility policy related to the accuracy of clinical records.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 97 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 98 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure standard procedures were followed to prevent the development and transmission of disease for 1 of 34 residents (Resident #51) in the survey sample. 1. The facility staff failed to clean Resident #51's glucometer after use. The findings include:	F 880	1. Glucometer machine cleaned per policy 2. All residents requiring blood glucose monitoring have the potential to be effected by this practice. 3. Director of Nursing or designee, will in-service licensed nursing staff on correct policy and procedure on glucometer cleaning and storage. 4. Unit manager, or designee, will audit 1-2 licensed nurses weekly for three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 99 Resident #51 was admitted to the nursing facility on 8/23/17 with a diagnosis of diabetes. The most recent Minimum Data Set (MDS) was a significant change in status assessment dated 12/11/17 and coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status that indicated the resident was independent and had no problems in the cognitive skills for decision making. The resident was assessed to have diabetes and on insulin. 01/17/18 at 12:00 p.m., during a medication observation, Licensed Practical Nurse (LPN) #11 did not clean the glucometer after use before she placed it in the zip lock bag and placed the bag in the medication cart. On 1/18/18 at 1:30 p.m., the DON stated it was expected the nurses clean the glucometer after every use no matter if it was a shared one or an individual one. The DON presented the manufacturer's recommendations that indicated the glucometer should be disinfected with approved agents and the cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of the meter after use. The facility policy titled Glucometer policy dated 5/2016 indicated "The med tech or nurse will clean the resident's glucometer after each use with a germicidal towelette."	F 880	months and then weekly for one month to ensure proper cleaning of glucometers. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 3/7/18	